Speaker 1: Good day. And welcome to the Integrated Planning Activities for Prevention and Care webinar. This conference is being recorded. At this time, I would like to turn the conference over to Julie Hook. Please go ahead.

Julie Hook: Thank you. And good afternoon and welcome everyone to this webinar on Integrated Planning Activities for Prevention and Care. My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistance Center. And I wanna thank everyone for making the time to be on today's call. During today's webinar, we'll present on the different models of collaboration or integration that jurisdictions can pursue, as well as the benefits and potential challenges associated with integrated planning activities. We have a couple of great presenters from Memphis and San Francisco who detail their jurisdiction efforts to integrate planning activities of prevention and care, and discuss lessons learned and promising practices.

Julie Hook: The slides are available now for download on our IHAP TAC website on the Target HIV website. The transcript or recording will also be made available on our web page early next week. Integrated HIV/AIDS Planning Technical Assistance Center, or the IHAP TAC, is a partnership between JFI, HELP HIV, and NAFSTAT, and is funded by the HRSA HIV/AIDS Bureau. Just as a reminder, the IHAP TAC, is a three year cooperative agreement to support Ryan White HIV/AIDS Program parts A and B recipients and their respective planning bodies with the overall integrated planning efforts and the implementation and monitoring of their integrated HIV Prevention and Care plans.

Julie Hook: We provide both national and targeted technical assistance and training activities. We provide support in the following areas:

Julie Hook: -Integrating HIV prevention and care at all levels, such as the different levels of collaboration and integration among prevention and care planning bodies, which is the focus of today's webinar.

Julie Hook: -Strategies for implementing Integrated Plan activities.

Julie Hook: -Publicizing and disseminating Integrated Plan activities to different stakeholders, such as communicating progress to planning councils and planning bodies.

Julie Hook: -Identifying roles and responsibilities for Integrated Plan activity implementation.

Julie Hook: -Monitoring and improving Integrated Plan activities.

Julie Hook: -And collaboration across jurisdictions.

Julie Hook: We'll be taking questions at the end of the call and will answer as many as we can as time permits. And you can use the chat feature to do so and ask

questions. I also want to mention, at the end of our webinar, the evaluation will pop up. And we hope that you fill this out as it helps us improve and inform future webinars in training.

Julie Hook: After today, you'll be able to: Describe types of integrated planning activities that jurisdictions can pursue; Understand the rationale and benefit of integrating planning activities of prevention and care planning bodies; And describe practical strategies to successfully implement integrated prevention and care planning activities.

Julie Hook: Now, I'd like to introduce you to our presenters today. Molly Tasso is on the IHAP TAC team here at JSI, and she's a technical assistance and training coordinator. She specializes in the Ryan White HIV/AIDS Program, healthcare reform in the ACA, and community HIV/AIDS planning efforts. We also are thrilled to have Parrish Oglesby, who is the planning group B manager for the Ryan White Program for Shelby County government, where he provides comprehensive support for all aspects of the Memphis Transitional Grant area planning group. In this role he facilitates all standing committees and planning group meetings, provides leadership development training to planning group members, and helps facilitate the completion of a comprehensive plan assessment of the administration mechanism and other special reports.

Julie Hook: We're also happy to welcome Mark Molnar, from the HIV Community Planning Council in San Francisco. Mark became a Santee peer support volunteer for individuals living with HIV in 1994. In 2000, he joined Santee staff and worked in a variety of roles including care coordinator, HIV and volunteer services manager, and HIV program director. He is the former co-chair of the San Francisco EMA/HIV Health Services planning council. In his current role of program director of volunteer and community services, he serves as the program director of the planning council support program for the San Francisco HIV Community Planning Council, which was created in 2016 by the merger of the former Care and HIV Prevention councils.

Julie Hook: So now that you've heard a little bit about us, we'd like to hear a little bit about you and just understand to see if you've been on an IHAP TAC webinar before. So, looks like there's an even split. So, for those of you that have been on a webinar before on IHAP TAC, we welcome you back. And for those of you, thanks for joining us. And now, I'd like to turn it over to Molly to kick off the rest of the webinar.

Molly Tasso: Great. Thanks so much Julie. So, before we dive into a discussion of the different models of integrated planning. We're first going to do a quick review of the different planning bodies that are required by HRSA and CDC.

Molly Tasso: So, as we all know, HRSA and CDC require HIV planning processes to involve community stakeholders, which include people living with HIV, vulnerable populations, HIV service providers and others affected by HIV. And the goal of

community involvement is to enhance the coordination, collaboration, and seamless access to prevention, care, and treatment services.

Molly Tasso: To put a sort of even finer point on it, you can see here language that's pulled from the Integrated HIV Prevention and Care Plan Guidance. That clearly states that all CDC and HRSA funded jurisdictions that are funded to do this work, are required to have a planning process that includes "the establishment of either an HIV Planning Group, Planning Council, or Advisory Group".

Molly Tasso: Let's just dive into the specific types of planning bodies. First is the Ryan White Part A Planning Councils or Planning bodies. So, according to the Ryan White legislation, part-A jurisdictions are legislatively required to establish and maintain a Planning Council or a Planning Body, which is an independent decision-making body that reports to the CEO, which is most often the city or county Health Department. And they work in partnership with the recipients.

Molly Tasso: Part-A planning councils are somewhat unique in that no other federal health or human services program has a legislatively required, community based, planning body that is the decision maker about how funds will be used and has such a defined membership composition. So for example, Part-A training councils are required to include 33 percent of representation being from unaligned consumers of the Ryan White Part-A services.

Molly Tasso: The planning responsibilities of training councils include assessing the needs of local people living with HIV, setting service priorities, establishing resource allocation decisions, and developing service directives. And they're assisted in fulfilling these tasks by the training council support staff, who is financially supported by the grant. And in addition to those activities, they're also responsible for submitting a letter of concurrence or non concurrence with the Integrated HIV Prevention and Care plan that I'm sure all of you are aware of.

Molly Tasso: And before I go on, I do wanna note that Ryan White Part-A TGA, so Transitional Grant Aras, can choose to form a planning body rather than a planning council. And in the context of Ryan White Part-A, those two words mean different things. So, if TGA ops for a planning body instead of a planning council, they're not required to follow the same legislative requirements as planning councils. But they still do have the requirement to engage in consumer and community input gathering for planning purposes. But just to be clear, HRSA strongly encourages TGAs to form a planning council instead of a planning body. And almost all TGAs have done so already.

Molly Tasso: The Ryan White legislation then requires Part-B recipients to engage in "a public advisory planning process". And grantees are allowed to manage Planning Groups internally or to establish Consortia. Consortias are outside planning groups comprised of associations of public and non profit healthcare and support service providers and community based organizations that the state contracts with to provide planning, research allocation and contracting,

program and system monitoring, and required reporting. And some of these are state wide groups, while other Consortia are specific to local areas or regions. And unlike Part-A planning councils, these planning bodies have no legislative requirements related to their specific roles and responsibilities or composition. And the planning group's recommendations are certainly taken into account during the planning processes. But their recommendations are not binding.

Molly Tasso: And finally, the CDC Division of HIV/AIDS Prevention funds all 50 state health departments, including Washington DC, Puerto Rico, and the US Virgin Islands to implement integrated HIV surveillance and prevention programs. And then, in addition, the CDC also directly funds seven local health departments, which includes Baltimore, Chicago, Houston, Los Angeles, New York City, San Francisco, and Philadelphia.

Molly Tasso: And the integration of the surveillance and prevention funds began in 2018, and was done to help health departments plan and execute more efficient coordinated and data driven prevention efforts. And so, these awards, they support two central CDC priorities. First they work to ensure that all people living with HIV are aware of their status and successfully linked to medical care and treatment to achieve viral suppression, and second, to expand access to PrEP, condoms, and other proven HIV prevention strategies for people at high risk of becoming infected.

Molly Tasso: And similar to the Ryan White side, the CDC also requires [inaudible 00:10:39] funded health departments establishing HIV Prevention Planning Group. So, these planning groups include community members, key stakeholders, and other HIV service providers involved in HIV prevention, care and treatment services. And they're responsible for informing the development of the Integrated HIV Prevention and Care Plans. And similar to the Ryan White Part-B Planning Group, the HIV Prevention Planning Groups are advisory and are not responsible for the allocation of fiscal resources.

Molly Tasso: Now, having gone through this overview of the different types of training bodies, let's turn to the various types of integrated planning activities. So currently, according to research conducted by Emily Gantz McKay Consulting, a review of the 2017 to 2021 Integrated plans found that 38 states and Washington DC deemed themselves as having an integrated statewide planning body. However, there are many nuances in terms of the level or intensity of this sort of self identified integration. On a similar note, the same goes for the more than 25 percent of Ryan White Part-A jurisdictions that have integrated prevention and care Planning Councils or Planning Bodies.

Molly Tasso: So, a good way to think about this is to think of the phrase "integrated planning body" as a catch-all term used to describe a planning body that incorporates, in some way, participation or input from both prevention and care. States and jurisdictions who have pursued this integrated planning have done so in response to the recognition that there are many benefits to pursuing this type

of planning structure. For example, integrated planning reduces reporting burdens and duplicative efforts by recipients and helps streamline the work of health department staff and HIV planning groups. It also helps to promote collaboration and coordination in the use of data for prevention and care program planning, resource allocation, evaluation, and CQI efforts.

Molly Tasso: More broadly, Integrated Planning efforts signifies a shift in the fight to end the epidemic. And it is done so in recognition that with the improvements in treatment and access to prevention technology such as PReP, we now know that treatment is prevention, and that the division and roles between treatment and prevention has largely disappeared. So overall, this approach to planning helps usher in a change in the scope and paradigm of HIV planning that promotes a more coordinated and comprehensive response to the epidemic.

Molly Tasso: So, what do we mean when we talk about integrated planning activities? What does this look like? Circling back to what we discussed earlier, integrated planning doesn't just mean one unified or fully merged prevention and care planning body. And it's very important to recognize that a fully merged planning body really is just not feasible for all jurisdictions, or is it rally the ideal way for all jurisdictions to go about their HIV planning work. So jurisdictions are really encouraged to explore different types and levels and models of integration to determine which option best suits their needs and to think of integration as an ongoing process that can be intensified over time, but that there's no need to rush anything.

Molly Tasso: So, I'm gonna walk us through five different types of integrated planning models that a jurisdiction can pursue. And these have been adapted from the research developed by Emily Gantz McKay and Hila Berl of EGMC. And although they should not be considered an exhaustive list of all integrated planning models or planning activities that you might be able to engage in, I think they will be helpful in giving you a sense of the options of the different things that you can pursue as you start to think about what this might look like and what might work best in your jurisdiction. So, for example, I'll provide a general description, and also an example that will either be real or hypothetical, of what these look like in practice.

Molly Tasso: So, the first type of integrated planning activity is information sharing, understood here as a situation in which each planning body informs the other planning body of their work using presentations, reports, webinars, conference calls and other communication activities. In practice, it might mean that a representative from the local HIV Prevention Group attends a Part-A Planning Council or Planning Body meeting, and provides a report on issues impacting HIV prevention services statewide and nationally.

Molly Tasso: The second model is called cross-representation, in which one or more members of each planning body serve as members of the other planning body. So, as demonstrated by this graphic, you have the red and the blue planning

bodies which operate separately. But then one person, or it could be multiple people, in the middle, colored yellow, they serve on both. So that is what we mean by cross-representation. And more concretely, this might take shape in the form of an HIV prevention group representative serving as a member of the Ryan White Part-A planning council or planning body. The next option is integrated information gathering and/or data analysis, whereby care and prevention planning bodies engage in data based collaboration through joint activities. These might include needs assessment activities, evaluations, consumer input activities, analysis of HIV Care Continuum data, and service planning or strategy development.

Molly Tasso: In practice, this might take the shape of a joint work group that includes prevention and care representatives that designs and implements a need assessment and develops the epi profile for both the state and the Part-A jurisdiction. It might also involve HIV prevention planning group representatives participating in the development of a Ryan White Statewide Coordinated Statement of Need. And we can also then look to Ohio where, in 2018, the Ryan White Part-A and Part-B programs and the Ohio Department of Health HIV Prevention program, they began conducting a multi-year joint statewide needs assessment targeting both Ohioans at-risk for infection and individuals living with HIV.

Molly Tasso: The next model involves the development of an integrated committee of a larger planning body. For this type of integrated planning structure, there's a standing committee on a larger planning body that carries out collaborative planning tasks for both prevention and care. As an example, this might include a Ryan White Part-A Planning Council or Planning Body establishing a standing Prevention committee or a joint program committee. And we can look to Houston, where the Part-A Planning Council has an Early Identification of Individuals with HIV work group. And it includes members of the Ryan White Planning Council and the Houston Prevention Planning Group, who together work on that strategy.

Molly Tasso: And finally, some jurisdictions may decide to pursue a unified prevention and care planning body. This is characterized by a single statewide or Part-A regional planning body responsible for carrying out both prevention and care planning. So, this might be ... Examples include an advisory body that might be housed within a State Health Department and that's responsible for conducting care and prevention planning. It could be a combined prevention and care planning body in a city that receives Part-A funds and directs CDC prevention funds, so those seven cities that I mentioned earlier. And then, we can also look to Saint Louis, San Diego, and Kansas City as examples, where, although they do not receive direct CDC prevention funds, they have integrated prevention into the work of their Part-A planning councils.

Molly Tasso: So, we have another poll here. And I'm just curious if people want to take a look and tick off any of the integrated planning activities that I just walked through. If

your jurisdiction might be engaged in any of these, go ahead and submit that. And it can be certainly more than one. It's not a sort of mutually exclusive list of options. So, looks like a lot of folks are engaging in integrated planning activities. Information sharing is certainly ... over half of you are reporting that you are engaged in that work, which is great, as well as cross representation and integrated committees. It's all really great to see.

Molly Tasso: So, I'm gonna go over to our presenters in a minute. But I'm just gonna briefly walk through some of the benefits that I did touch on earlier, but also some of the potential barriers to implementing these integrated planning models. So first, the key benefit is that it provides an opportunity to look at the full spectrum of needs across the entire HIV care continuum, without being limited by the restrictions associated with funding streams. And this is especially important as we think strategically about ending the epidemic. Integrated planning also facilitates engagement with a broader group of stakeholders.

Molly Tasso: And for example, it can help create opportunities to provide education on prevention and care. For example, in the context of a discussion related to a Part-A jurisdiction conducting their priority setting and resource the allocation work. And finally, integrated planning activities promote and support efficient use of resources, especially for people who might serve on both planning bodies. It is important though to also be aware of potential challenges that you might face while implementing some of these integrated activities.

Molly Tasso: So first, and perhaps the most obvious, is simply that Ryan White Part-A, Part-B, and HIV prevention planning groups, they have different roles, responsibilities and requirements and they serve different functions, namely either as an advisory group or decision making group. And so that reality is something that you need to know from the beginning and be able to then work through as you develop and think about a new planning structure.

Molly Tasso: Second, cultural and procedural differences between planning bodies may prove challenging, specifically the culture and general feel of any group, such as their level of formality, [inaudible 00:21:35] and customs, how their meetings are run, all of that is unique to Planning Bodies.

Molly Tasso: So, special attention must be paid to make sure that everyone feels comfortable, feeling like they have a seat at the table, and that they are able and willing to participate fully in those meetings. And somewhat similarly, historic relationships between prevention and care across Ryan White parts within the local community may carry with it sensitivities that need to be named and recognized and addressed during the process of the integrated planning activities. For example, members will really need to think more broadly and beyond the scope of them only representing care or only representing prevention.

Molly Tasso: Those of you who implement integrated plan activities may find it difficult to maintain a manageable membership level while still meeting, for example, Part-A Planning Council legislative requirements. So, for example, it may be a little difficult to include enough people from prevention to ensure that it is meaningful representation. And we're also making sure that one third of voting members are consumers of Ryan White services, which is a Part-A requirement. Similarly, with a broadened membership and scope of focus, an Integrated Planning Body must effectively manage meeting time to complete all required activities and meet all deadlines. And there also may be administrative and financial challenges to overcome, seeing as prevention sometimes has less money for planning than Ryan White does, and it's important to ensure that power is evenly distributed amongst the group, regardless of who is perceived as financially supporting the planning work and making sure that trust is built for all at the table.

Molly Tasso: So, before I hand it over to our presenters, I just want to underscore the point that I made earlier, that every jurisdiction is different and that there's no one size fits all for integrated planning. There's no correct structure. And factors such as leadership, membership, frequency of meetings, and structure of work group and committees, they'll look different in every jurisdiction. We wanna be clear that HRSA does not recommend any particular structure of an Integrated Planning Body, but really encourages all of you to consider what's best for your community and what will really help facilitate achievement of the end house goals, and ultimately end the epidemic. So thank you so much for your time. I'm gonna hand it over to Mark from San Francisco now.

Mark Molnar: Hi everyone. So, I'll be going over the sometimes rocky road to combining the Care and Prevention Councils, and then going over what the current merged body looks like, and some lessons learned. So, let's just dive right in. The idea of merging the two councils was not a new one. Way back in 2004, an HIV Work Group was convened by DPH leadership, included service providers, community members and planning council members. Had a whole host of recommendations including the idea of looking at merging the two HIV centered bodies.

Mark Molnar: The members of the work group brought that back to their respective councils and to their respective departments. Unfortunately, there wasn't actually a lot of interest at that point. So, time marched on. And the first sort of signs that we could be looking at integrating more closely came about actually through one of our Part-A service categories within ambulatory care, but also one we call the Centers of Excellence. It's a one stop model of integrated services. And that has been around for a few years, but because there was just increasing talk around sharing information between prevention and care and not being so siloed. One big stop was to actually integrate prevention before ... with positive interventions within [inaudible 00:25:34]. So that was, in some ways, the first step that involved money.

Mark Molnar: On the council side, a Point of Integration Committee was created that included members from both planning bodies. That lasted for a few years. The main goals there were to review the disparities of different communities and to have proposals around how to reduce those disparities. So, that was a great way for the councils to get to know each other. There are some challenges there as well, basically around the different goals of prevention and care. And so, even though this committee did come up with quite a few ideas and proposals, very few, if any of them, actually went anywhere.

Mark Molnar: So, the years passed by, and there became more talk, not just locally but on a national level, about the importance of prevention and care talking to each other, and whenever possible, collaborating and even integrating. Of course Obama's National HIV Strategy was unveiled. And there was language in there around more integration. A few years later came a joint letter actually from the CDC and HRSA encouraging these bodies to talk to each other and perhaps collaborate, perhaps integrate. And on a local level, our DPH and the mayor at that time had begun really looking at both of those two planning bodies as bodies that should be one body.

Mark Molnar: Part of that was because both prevention service providers and community members, and care service providers and community members, were very good at advocating directly to the mayor and to DPH. And so, part of that was they should just advocate together. A lot of what they're talking about around disparities and around the communities they want to target are actually the same things. And there's also just the growing feeling that there's so many lessons learned, that Care could have from Prevention, and Prevention could have from Care. So, why aren't they ... not just talking to each other. Why aren't they looking at the entire system as a continuum rather than two separate silos?

Mark Molnar: So, the merge talk began. Both councils took this very seriously, in particular, because ... I think I might have skipped this part. Maybe not. There we go. And particularly because, Bobby Garcia, the DPH head at that time, came to speak to both councils and outline her vision of we need to look at HIV as existing on a continuum. So, after that, the idea of merge was taken very seriously. A Merge Task Force was convened. It included the leadership of both councils as well as different nominated members from different parts of the department and other service providers. A consultant was hired. This consultant was very much experienced in the continuum of HIV prevention care. He often would do the grant evaluation as well. This group came up with three different models of merger. They were quite dissimilar to each other. The idea was they wanted to present these three models and let the larger group decide which one they chose.

Mark Molnar: They also decided to put off determining any specific policies and procedures. And that included what the council membership protocols would be. Who would actually be a council member? So, after about a year of work, it came to a vote. There were two concurrent meetings of the Prevention and Care Council,

the Prevention Council. The vote passed. They wanted to merge. When it came to the care council, literally minutes later, after very robust and sometimes very emotional discussion, the Care Council decided to not merge. So, everyone took a long deep breath. And that deep breath took about a year. It was thought, because of so many strong feelings, so many emotions, just so many challenges, that were brought during the two different meetings where one was approved and one disapproved, that we just needed to step back and just let everyone sort of relax. Because it was a time just fraught with tension.

Mark Molnar: But during that time, there was still work being done. Because of the changes in healthcare, an Essential Health Benefits Work Group was formed to address those changes here in California. And that included members from both councils. So, both councils were still talking to each other. In the meanwhile, my staff and I decided to talk to the council members quite specifically about what was challenging about the idea of merging. So, we interviewed council members to hear from them, why don't you wanna merge? What kinds of things, what kinds of feelings, what kinds of fears do you have that led to this not happening?

Mark Molnar: And we presented this, the data from these interviews, to the leadership group of the council, as well as to the PLWH advocacy group. From this data, as far as the challenges with merging, came a series of motions. And those motions really outlined what the specific fears were. And they were quite specific around membership protocols and the importance of centralizing consumer voices. So, in some ways, that first merger task force did not understand that there was fear around even being allowed to be part of a merged council. The council members had seen what had happened on the prevention side many years past, when the Prevention Council reinvented itself, and many current members were not able to come back on.

Mark Molnar: And so, there was a lot of fear that that would happen with this council. And so, a series of motions were generated and brought to the Care Council that established that these would be important goals in any future merge process. So, after that year, there was a second attempt. And so it was a two-step process. The shorter step was to create a transition team. This was composed of not only the council members, as well DPH staff. The transition team's purview was really to change bylaws, but to establish what the following group would actually be doing. It was a group that really set the process. At this point, a new consultant was hired. The group felt that perhaps hiring a consultant who has expertise in one of the two areas, prevention rather than care, was a part of the challenge. Even though he was great, he had sort of the deck stacked against him because he was seen as a representative of Prevention.

Mark Molnar: So instead, they went really outside of the box and hired a consultant whose main expertise was not around HIV prevention and care. It was around modes of communication and community planning. So, the transition team created the parameters for the following group. And they put forward a motion for both councils for a bylaws change that would allow the leadership bodies of both

councils to come together as one. And so the joint leadership committee was formed. The joint leadership committee did two things during their regular monthly meetings. They did merge activities, but ... which I'll get back to. But they also, and sort of just as important, they also continued to conduct regular business as the leadership committee for both councils, which meant that the leadership of both councils was now experiencing, in real time, what it was like to do community planning on the other council.

Mark Molnar: So, that was just a very important step as far as ... for lifting the veil of what the other councils did. As far as what this group did around the merge, they looked at those three models and they made a final decision. They decided that there was too much ambiguity there when three models were presented. So, they decided to focus on one. They responded to the motions that I mentioned that were brought before the former parent council. And they actually did finalize membership and council composition requirements, and the approval process. Basically, they just decided to grandfather in all existing council members, to that fear could not just be managed, but just be erased.

Mark Molnar: And then, they also reviewed all bylaws, as well as most of the policies and procedures, and all of the membership requirements from both councils, and they unified them. So, there was one meeting 2015, and three meetings in 2016, of both councils. These were joint meetings. And these were mainly reviews of all the different policies and procedures that this joint leadership group had been working on. So, as they worked on them, they collected them and brought them to one of these four meetings. And so, discussion on all the different new membership protocols, on all of the merged and sometimes changed or updated and sometimes discarded policies and procedures, were reviewed by everyone all at once.

Mark Molnar: And because of, I think, the experience of now working together, rather than just having a vote about coming together, by the time it came to a second vote in June 2016, it was like a unanimous vote in favor. So, in the current structure, we have a range of committees and work groups. We have a Steering Committee, which is of course composed of council leadership. And that involves all the committee co-chairs. We also elect at-large members. All council members must have a home committee. In the beginning, it was decided that government appointees did not need to have a home committee. But soon, there began to be tension around the idea that one particular council member type had that lifted. And so, the mandate now is that all have a home committee.

Mark Molnar: And those committees are: our Community Engagement Committee; our Council Affairs Committee; and our Membership Committee.

Mark Molnar: Membership Committee pretty much speaks for itself. Council Affairs Committee, they really design the presentation calendar. And they also look at things from the perspective of service providers and government appointees.

The community engagement committee will accept things often from the HIV positive or HIV negative, but still considering an HIV Prevention consumer services perspective. So with that, they also oversee our use assessment, the range of our focus groups that we implement throughout the year, and our HIV consumer advocate reports to that committee. We have a range of work groups as well. Of course, they are all ad hoc.

Mark Molnar: We have a Needs Assessment Work Group. We have a new work group called the Homeless Work Group. It's a major challenge in San Francisco. And so, this has been recently created. We have our Integrated Plan Work Group that comes and goes when that work is needed. And the PLWH Advocacy Work Group was re-established. This is a highly important group because the main block of members who actually blocked the first merger were the HIV positive consumers of services. And so, restarting that in the merge council was seen as a given. It absolutely had to start again. And the council itself meets once a month for three hours. All committees meet for about two hours.

Mark Molnar: About a year later, we wanted to do a check in with ourselves. So, we hired a consultant to evaluate the merger and determine any post-merge challenges. This consultant, Sully Potente, conducted a number of one-on-one interviews and several focus groups. The primary findings of the challenges that either still existed or were new challenges to the newly merged body ...

Mark Molnar: Perhaps, number one was resistance to being passive recipients of information during full council meetings. And I'm sure you guys have all been there. A lot of times, meetings have a lot of PowerPoints. And have just a lot of information that you're supposed to listen to and just process, which can be a passive experience, and doesn't necessarily feel like you are in any way in an empowered position. There was of course, in some ways predictable, a lack of understanding of the prevention care by those care council members who didn't have experience with it and vice versa.

Mark Molnar: And there was, of course, resistance to being viewed as a rubber stamp council in which DCH would simply bring you different ideas and there would be automatic approval. There was a big ... There was anxiety around that, and a real need to establish the newly merged council as a partner to DPH rather than the last place that DPH goes. So, the leadership of the group ... of the council, thought this over. And they brought these findings as well to the larger council, and decided to implement some changes based on those findings.

Mark Molnar: First of all, it was to actually implement training. Trainings had been implemented all along, but they were sparsely attended, I think because many of the council members are coming from places where they have full time jobs or they just have lives. Showing up at trainings was not something that a lot of council members did. So, we decided to bring the trainings to them. Our meetings are three hours. And so, we are able to fit in some fairly basic foundational trainings including the reviews of the Ryan White Part-A service

categories, a review of the behavioral risk population on the prevention side, et cetera.

Mark Molnar: There's also a desire to make sure that the newly formed HIV community planning council is not now in its own silo. And so, there was a greater effort to make sure that we're connecting with other bodies, including the Getting to Zero initiative, which has been very successful here in San Francisco. I should also mention that our state Part-B representative sits on the council as well. She joins for every meeting either in person or via Zoom. And we have a representative on the California Planning Group as well. We also decided just to limit the number of presentations per full council meetings to two. And we decided to make them not all the same kind of presentation, which is just the standard PowerPoint. So, we really mixed it up. We've had guest panels. We have small group discussions where the council divides into groups of five or six. We have feedback sessions, post-it walls, dyads, triads. We just really try to mix it up as much as possible. So that when people are receiving information and also making decisions, that it's not just a person sitting in a chair and looking at a presentation.

Mark Molnar: Part of the anxiety that came with being on the newly merged council was arrival of a bunch of new people. So, suspicions came, and just anxieties were felt around, who was this person? Does this person have more expertise than I? I'm suddenly now shy to talk. All those different things were things that people were living with as council members. So, we decided to humanize each other by doing a multi council member panel. We have three council members who literally have 15 minutes to talk to the rest of the group about why they're on the council, what activities they think are the most important on the council, that they can really connect to on a personal or professional level, and what they'd like to actually see the council work on in the future.

Mark Molnar: This has been super important, for people to get to know each other and to feel comfortable enough to actually use their voice in meetings. Another very important thing that needed to be processed and understood was that there had to be new work that happened. A newly merged council just can't continue to do the work of the former prevention and care councils. The two councils have merged. They integrated. And so, what better body to look at integration across all of the different systems? And so, a roadmap task force was established in collaboration with DPH.

Mark Molnar: We've been lucky. We have very strong advocates with our partners in DPH. And so, this task force has been established and reviewed different kinds of efforts, from Getting to Zero, to internal DPH efforts, to efforts on service provider level, to make sure that prevention, HIV care, Hep C, STI, mental health, substance use and jail services are all talking to each other, so that these kinds of silos don't continue to remain. And the other group also introduced different motions for HCPC approval regarding that systemic integration change.

Mark Molnar: And so, the three lessons learned. The first one, of course is that there has to be commitment to establishing new norms. A newly merged council cannot be just the same version of the former two councils. You have to establish new norms. And so, that means new ways of perhaps communicating with each other. We've had discussions just on how to communicate with each other, for example, as well as not necessarily being wedded to what has been done in the past. And that could be anything from [inaudible 00:43:30] to how we prioritize, how we allocate resources, to how we receive information. Everyone needs to be sort of all in, in the idea that this is a new body. We of course, learn that community voices must be centralized. The HIV positive voice was very very strong on the care council, and continues to be strong on the new merged council as well.

Mark Molnar: In addition, community voices beyond HIV positive ones should be centralized as well, and so that means people from different service agencies. Centralizing the positive voices and the voices of people who have these years of experience goes a long way to making sure that council members feel that they are not a rubber stamp council, that they are seeing themselves in leadership, leadership of the council, and leadership in committees. And because of that, we have specified certain chairs within our leadership. So, our co-chairs have to include at least one person who is a HIV positive consumer of services. It has to include at least one service provider. It has to include someone who is either an HIV prevention consumer of service or someone experienced in the HIV prevention system of care.

Mark Molnar: And we also include a DPH co-chair. We actually have one representative from prevention and one from care, and they share a vote. This was new for the care council, and also, in some ways, new for prevention council. Prevention council had had a DPH as co-chair of the council. The former care council did not. And so, this was new in some ways, this shared vote. And then, of course, the work must be collaborative. So that means the work has to be collaborative with our partner, DPH. Planning has to include council members. And the council has to include DPH in the plans. So, those are lessons learned that we have right now and I'm sure there will be more as we move forward.

Mark Molnar: We still are a fairly fresh council. And with that said, I'll turn it over to Parrish.

Molly Tasso: And thank you so much Mark. This is Molly. Parrish, I'm just gonna let you know, I know that it's at 12 'til. But please take the 15 minutes that you need to give us your presentation. We want to hear everything you have to say. And then, we'll follow up with folks with your questions individually. So Parrish, take it away.

Parrish Oglesby: Okay. Thank you so much. A lot of the stuff that Mark hit on, my planning group, Memphis TGA, went through those things. Fortunately for me, I don't know about them, but I took over it in 2015. All the hurt feelings and everything ... I mean, [inaudible 00:46:22] TGA was in a disarray for a minute because of we had a lot of turnover. We had a new mayor come in. And we were basically

under the Mayor as opposed to be ... or the Shelby County government as opposed to the Health Department.

Parrish Oglesby: But a little bit about ourselves, the Part-A was started in 2007. And what's unique about is that we have ... Our TGA consists of 8 counties over multiple states. So, for instance, Shelby County, Tipton, and Fayette is just in Tennessee. Then we have Crittendon county in Arkansas. And then we have DeSoto, Marshall, Tate and Tunica in Mississippi. So, just add that to the ingredients. You're talking about a bunch of committees under prevention. And then you have a bunch of committees under care. And then you have all those different meetings throughout the month and you have ... You create cliques and you create silos.

Parrish Oglesby: The Planning Council was established that began work in March of 2008. A little bit about us demographically. Out of all those 8 counties, we have 7,292 people that are affected with HIV. Of that, we have about 3,866 clients that are actually served under Part-A. Our prevention funding started in January of 2013. So even though the service are reserved for individuals living for just the southwest Tennessee region of Shelby county, Tipton, and Fayette county, those are the only thing that was represented in terms of prevention.

Parrish Oglesby: So, when I came along, I was kind of ... I told Molly early on that my favorite boss in the whole wide world, her name is Jennifer Pepper. She's no longer with us. She moved on to bigger and better things. She kind of didn't tell me all of the background of all of the hurt feelings and everything. When I came on board, she was just like, "You know what? In order for you to really make this into a success, you have to be innovative and do like all the other great TGAs were doing. And integrate the planning council."

Parrish Oglesby: So, I was just like, "Okay. Well, if that's what's gonna make us great, that's what I wanna do." So, I took over it not knowing all the background to it. So, that was something that she did that really worked me. The whole thing, for us, it took about seven months to finalize. And it led to us being more streamlined. Everybody was on the same page. The bylaws and the policy procedures took about a year and a half. And it was an ongoing thing. Because there's always something that you're not going to catch. The biggest challenge was gaining trust, of course, something that Mark talked about.

Parrish Oglesby: We had prevention whose dollars weren't nowhere near as much as care's. We get 7 million dollars just for care, and maybe a few hundred thousand dollars for prevention at the time. So, that was ... It was really a tough situation for a lot of people coming in, thinking a prevention was not gonna get the support it needed. So, that was the sore point of the whole conversation. So, we had to do a lot of pulling in of different people from Tennessee, Mississippi, and Arkansas. So, we created an ad-hoc meeting of leadership, where we took from ... We had to do everybody that was a stakeholder from prevention and all the stakeholders from care.

Parrish Oglesby: Now, we had a drop off. A lot of people, when they knew that we were gonna actually do this, we were going to go forward with this, a lot of people quit and I haven't seen them since. But the people that actually stayed, they really wanted to hash it out. I had the prevention and I had the care, but I also had stakeholders from government, from the clergy, from community activists that were actually pulling the strings. So, I had to go get them into the seat, in Mississippi and in Arkansas. So, we got us all in this big room with our ad-hoc meeting that we had every month, a room with the existing committee meetings that were actually going on. And we had to get past the feeling part of this, and make it about business and being professional.

Parrish Oglesby: So, what we would do with all the feelings and things that are hot buttons that would get us in trouble, we would put tha tin the parking lot, saying that once we got all these things taken care of, and we had created this HCAP, as we call it, HIV Care and Prevention, Planning council, that we will address all those hot button issues. But it had to be a lot of choice to be involved. So, one of the things we wanted to focus on was what could we agree on, not what we couldn't. So, each meeting, we had to put your ego to the side and say, "What could we agree upon?" Not what we disagreed on, what we could.

Parrish Oglesby: And put everything else that we disagreed on into the parking lot. The meetings took, like I said, six months. And the stakeholders were the biggest thing because a lot of times, the stakeholders weren't saying anything. They would say things in the other meetings. And they were pulling strings. So, I had to actually ... Me and the staff had to actually go out and find out who were the actual stakeholders. And once we gathered as many as we could, that is when the ball started to actually rolling.

Parrish Oglesby: The H-CAP formally was created in spring of 2017 and comprised of 25 to 36 members based on HRSA's requirements. Currently, we're at about 35 full-time members, with about 4 alternates. It's two planning group's chair, a secretary, three standing committee chairs, four convention representatives to the Tennessee ... where I'm at right now, the Tennessee Community Planning Group, or the TCPG. To make this thing work, also was the training. Because we were gonna make changes to the bylaws, because we were gonna make changes to our policy and procedures, our conflict of interest, our code of conduct. We will make all these changes and put them all as one, it took a lot of training, a lot of orientation, a lot of hesitation.

Parrish Oglesby: And we were gonna take months. And also, once we got the parties together to come to this, it was inevitable, by the way. It wasn't one of those things where we could say we had the option, because it had to be all hands on deck and everybody had to have skin in the game, you also had to work to ensure that it was successful. And those extensive training was very very important to our overall success. Once we got the training going, we started to the next level of training the trainers. Those were the people that were gonna ...

Parrish Oglesby: 'Cause we had some drop offs. So, we always was bringing in new people, new people that were interested in being a part of this new change. So, we had to train those people as well. So, it was always an ongoing ... And even now, we still have orientation three or four times a year to keep people up to date and keep people going, in addition to our committee meetings. Each H-CAP member represent a prevention and care. So, we had to remove the silos. The silos were definitely a killer. And sometimes, even in that situation, silos would pop up. But we wanted to bring ...

Parrish Oglesby: We have one big meeting at the end of every month, the last Thursday of every month, where everybody, all the committees come together. So we are sharing information. At the end of the month, we're having our weekly meetings or our monthly meetings. And then, we have one big one where everybody comes together to eliminate the silos. Also, in our work plan, we make sure we have an integrated committee, we have a community partnership meeting, and we sometimes have those meetings together to share ideas, best practices.

Parrish Oglesby: Some committee meetings are a little stronger than others. So, that's our train the trainer aspect to that. So, we also want to formalize transparency too. That was a huge concern when it comes to dollars. So, we have badges that you put around your neck when you come to every meeting showing your conflict of interest. If you are a person who is with [inaudible 00:55:24], if that is your company, [inaudible 00:55:34] conflict of interest. But you got it around your neck, so everybody know what division you represent or what's most important to you at the time.

Parrish Oglesby: The lesson learned and the promises of practice ... I think Mark had a consultant. I wish I had it. We didn't think of having consultants. I have a background in project management and it helped a lot. And I had a great team behind me to be a referee and make sure that no one would come in and hijack the meeting. When you hijack the meeting, it can go off into so many different directions. And then, we get into our feelings again. And we get off course. Recognize the personalities at play and honor the ways that personal life experiences ... how it impact person's dedication to a planning group. That was huge because everybody ...

Parrish Oglesby: At one point, it felt like everybody had a personal agenda. But when you had the conversation where you talked to one another and related to one another, [inaudible 00:56:43]. We also have a yearly retreat. We have the one coming up next week, May 3rd. And the retreat allows us to put aside all work and everything. [inaudible 00:57:02] next year.

Parrish Oglesby: But it also, if we identify something about weaknesses, we bring it into our [inaudible 00:57:13] and work on it like team building skills, conflict resolution skills. It's always about ... H-CAP for us is not just about HIV care and prevention. It is about developing those who are consumers who need those skills to be able to transition. Our theme this way is gonna be, knowing your status, but thriving

once you know. It's about thriving this year. Know now, live longer, thrive is our theme this year. And that's a huge thing because we wanna develop people to where you can care for yourself, transition off, and live a long and healthy life with HIV.

Parrish Oglesby: So, in a nutshell, those are the things that we learned. I'm so thankful. I like this. I keep saying "I" a lot. But the biggest thing for me is the TGA that I work for, Mississippi, Arkansas, and especially Tennessee, we have a lot of consumers. Like I said earlier, HRSA [inaudible 00:58:21] have 33 percent of unaligned consumers. In our H-CAP, we have 56 percent of unaligned consumers on our planning council. So, we got buy in from consumers, providers, from advocates, to clergy, to government, to healthcare. It's all at the table.

Parrish Oglesby: And I would like to say that if it wasn't for them putting their egos to the side, if it wasn't for them allowing me to push sometimes, if it wasn't for them for doing the hard work in terms of polished procedure, the [inaudible 00:58:55], the conflict of interest, and all those real interesting pieces, I don't think we would have made it. But now, I can honestly tell you, it is a strong ... They don't need me anymore. I think that was my hope for coming on board for us, to work myself out of a job. We've got some really good ...

Parrish Oglesby: There's consumers and providers on our planning council. That's all I have.

Julie Hook: Great. Thanks so much Parrish and Mark and Molly. We are sort of at time. So, there were a couple of questions that came in. But we will follow up with the presenters, and then follow up with you folks to get those answers to those questions for you. We do have our archives and upcoming webinars available on our IHAP TAC website. We have another one coming up that's still TBD around leveraging HIV prevention and care programs to include ATV services within health departments. We encourage you to visit our website to check out our resources and our archive and upcoming webinars, or to access our list serve. And we thank you in advance. And just wanna ...

Julie Hook: You can go ahead, and we're going to launch the webinar. So, we thank you in advance for filling out this webinar and for participating. We thank you for listening in today. Have a great afternoon.