Julie Hook: Good afternoon, everyone. And welcome to this webinar. Moving Integrated HIV Prevention and Care Planning into Action: Health Department Structural Changes to Advance Integration of HIV Prevention and Care Services. My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistant Center, and I want to thank everyone for taking the time to be on today's webinar.

Julie Hook: As health departments actualize their integrated HIV prevention and care plans, many jurisdictions are considering integrating implementation, monitoring, and evaluation of HIV prevention and care services within the health department as well as integrating funding streams in order to facilitate greater integration of prevention and care services on the ground. The goal of this webinar is to provide information on what jurisdictions should consider as they start to think about integration.

Julie Hook: I just wanted to let people know that the slides are available now for download on our website if you want to download them and take notes as you go.

Julie Hook: The Integrated HIV/AIDS Planning Technical Assistance Center, or the IHAP TAC, is a partnership between JSI, Health HIV, and NASTAD and is funded by the HRSA HIV/AIDS Bureau. As a reminder, IHAP TAC is a three-year cooperative agreement that began in 2016 to support Ryan White HIV/AIDS Program Parts A & B recipients and CDC Prevention grantees and their respective planning bodies with the overall integrated planning efforts and the implementation in monitoring of their integrated HIV Prevention and Care Plans. We provide both national and targeted technical systems and training.

Julie Hook: We provide support in the following areas: integrating HIV prevention and care at all levels, including integrating planning bodies, strategies for implementing Integrated Plan activities, publicizing and disseminating progress on the plan activities to stakeholders, such as communicating progress to planning councils and planning bodies, identifying roles and responsibilities for Integrated Plan activity implementation, monitoring and improving your Integrated Plan activities, and collaborating across jurisdictions, including across the Prevention and Care in Part A & Part B.

Julie Hook: We will be answering questions at the end of the call, we'll answer as many as time permits. If you have questions, please chat them into the chat feature. I also wanted to mention that after the webinar ends an evaluation will pop up immediately and we hope that you'll fill this out as it helps us to inform and improve future trainings.

Julie Hook: We hope that after today you'll be able to describe the value of integrating HIV prevention and care service delivery within health departments, identify at least one program activity supported by integrated prevention and care service delivery, and identify at least two strategies to facilitate integrating HIV prevention and care service delivery.

Julie Hook: Now I'd like to introduce our speakers, first we'll have Marissa Tonelli, who is a Senior Capacity Building Manager for HealthHIV and a member of our IHAP TAC team, she leads HealthHIV's 3D HIV prevention program, a technical assistance program that enhances the ability of health departments, ASOs, CBOs, and health organizations to conduct enhanced data collection analysis to make better informed pragmatic decisions.

Julie Hook: We also have Dawn Fukuda who is the director of Office of HIV/AIDS in the Massachusetts Department of Public Health Bureau of Infectious Disease and Laboratory Sciences or BIDLS. She has served as Massachusetts state HIV/AIDS director since 2010 and has worked within the office of HIV/AIDS for the past fourteen years.

Julie Hook: We also have Robert Winstead who is the HIV Care Program Manager from the Division of Public Health Communicable Disease Branch from the North Carolina Department of Health and Human Services.

Julie Hook: And Pete Moore who is the manager of the HIV/STD Prevention Program, also with the North Carolina Department of Health and Human Services.

Julie Hook: Now I would like to turn it over to Marissa.

Marissa Tonelli: Good afternoon everyone and good morning to my colleagues in Hawaii, Guam, and the Mariana Islands. My name is Marissa Tonelli and as Julie kindly mentioned I serve as a Director of Capacity Building for HealthHIV. HealthHIV is a national nonprofit and we're working with JSI on the IHAP TAC to conduct training and technical assistance on how health departments and operationalize their integrated HIV prevention and care plan. I'll be providing a brief introduction today to this collaborative webinar on Integrated Health Department Models.

Marissa Tonelli: So the drivers of integration from a federal level, starting with the national HIV/AIDS strategy, the fourth goal of which is to achieve a more coordinated national response to the HIV epidemic. And since then federal activities to address goal four have included addressing HIV care and how we are coordinating data and surveillance integration and integrated HIV prevention and care planning.

Marissa Tonelli: In 2015, a federal level coordination effort to facilitate the integration of HIV prevention and care services came in the form of a joint guidance. This would be Integrated HIV Prevention and Care Plan that was being submitted and as you all know the integrated plans were submitted to both CDC and HRSA in the fall of 2016.

Marissa Tonelli: CDC and HRSA expect jurisdictions to utilize these plans to inform their HIV prevention and care planning, community engagement, resource allocation, evaluation, and continuous quality improvement efforts in order to meet the

HIV prevention and care needs of their jurisdictions. And this plan is really acknowledged as a living document that will likely be adapted over the next five year period.

Marissa Tonelli: One of the key priorities really for integrated HIV prevention and care planning is to not only reduce the reporting burden but also to de-duplicate efforts and streamline the work of health department staff and HIV planning groups and ultimately to improve the efficiency and focus of HIV prevention and care services.

Marissa Tonelli: So we're gonna talk about why integrating.

Marissa Tonelli: So I wanted to start and kinda back up a little bit and discuss what we mean by integration as it can be applied at many different levels. One way we can talk about it is integrated care which is a package of preventive and curative services for a particular population group. We also talk about integrated health services which is a range of services provided at one location. And integrated service delivery which the World Health Organization defines as the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.

Marissa Tonelli: So I wanted to point out that levels of integration have been examined by a variety of federal agencies, including SAMHSA in HRSA's centered for integrated health solutions, which identifies five levels from minimal collaboration to full integration, as well as the Centers for Disease Control and Prevention, CDC's Program Collaboration and Service Integration, PCSI, initiative which identified three levels of service integration from non-integrated services to expanded integrated services.

Marissa Tonelli: But while different and having different levels, all the models and initiatives agreed that full integration usually includes shared systems and facilities, a well defined and mutually beneficial relationship between two or more programs, a collaborative routine, and lastly a seamless comprehensive delivery of services for clients without repeated registration procedures, waiting periods, or other administrative barriers.

Marissa Tonelli: So why do we integrate? Well beyond federal level guidance that is now supporting this integration, health departments across the country are integrating programs and services for a variety of reasons and these may include to enhance the capacity to address multiple health-related goals, to respond to syndemics with similar risks for acquisition, such as HIV and STIs or HIV and Hepatitis C, to decrease barriers to providing services, to maximize opportunities for people to receive the best care and treatment when they interact with providers across disease states and conditions, so that the care really is comprehensive, to eliminate duplicative services, and ultimately to maximize, what is very limited for some states, federal and state resources.

Marissa Tonelli: I would encourage you all to now be getting to the Q&A to take a minute and share maybe in the chat box, is possible, why your health department is choosing or considering integrating programs and services. We'd love to hear your thoughts.

Marissa Tonelli: So some opportunities to collaborate which already exist might include community planning such as integrated HIV planning bodies, data and that would include data sharing, joint surveillance and cross-matching cases, cross-training of staff and providers on co-occurring conditions which might include extra genital STI testing for men who have sex with men, accessing PrEP services, collaborative funding opportunities for community providers in some case and staff sharing among programs, which would help reduce administrative costs.

Marissa Tonelli: Some opportunities to integrate service delivery might include testing at all levels, outreach and education, partner services, substance use and harm reduction, especially as we continue to see increases in opioid use and co-occurring opioid and infectious disease epidemics, PrEP, syringe service programs, HepC testing and treatment, and, again, integrated surveillance and health insurance enrollment can all be integrated across programs.

Marissa Tonelli: So I wanted to share just one example quickly of a structural level integration that has already seen some benefits and that happened at the San Francisco Department of Health, probably about four years ago now. And what they were looking at, the Health Department's really trying to understand the social determinates of health and the root causes of community health and well being and use that to realign its prevention programs and integrates under one branch.

Marissa Tonelli: So they created the Community Health Equity and Promotion Branch, CHEP, which uses a comprehensive approach across the spectrum of prevention programs by integrating HIV prevention, viral Hepatitis prevention, STI prevention, tobacco cessation, substance user health, heart disease prevention, and injury prevention, and wellness initiates all under one umbrella.

Marissa Tonelli: And they did this by also ensuring community engagement and input across all the programs, in order to really effective address health disparities that they were seeing among men who have sex with men, transgendered females, and racial and ethnic minorities in the city of San Francisco.

Marissa Tonelli: Some of the benefits in just a couple of years they saw from this restructure included an increase in clients screened for Hepatitis C, there was almost three times more the following year, and an increase in the number of clients that were initiating primary care based treatment for HepC. They also saw an increase percentage of programs that they were able to create that intentionally Black and African American health disparities including HIV, smoking cessation, and some other wellness initiates. And they also saw an increase in targeted, collaborative programs that were focused in health equity, such as vision,

smoking cessation, syringe access, HIV, Hepatitis C, and STD testing, all which were seen as kind of available services within one block in the Tenderloin neighborhood and they were able to see how these co-located services could improve health equity for populations at risk.

Marissa Tonelli: So I'm gonna move on and turn it over to Dawn Fukuda from the Massachusetts Department of Health where she serves as the Director of the Office of HIV/AIDS and invite her to talk about the Massachusetts experience in integrating their HIV prevention and care services. So Dawn.

Dawn Fukuda: Great, thank you so much and good afternoon or good morning everybody, depending on where you're calling from. My name is Dawn and I'm the Director of Office of HIV, where a state here in Massachusetts with 6.5 million residents and approximately 25000-27000 individuals who are living with HIV infections. And we have between about 650-700 new infections, HIV infections, every year.

Dawn Fukuda: And what I'm hoping to do is actually tell more of a story as I share some slides with you. The goals of integrated state plan include reducing new infections, improving health outcomes, and reducing health disparities, and in our case these objectives apply not only HIV but also viral Hepatitis, sexually transmitted infections, and tuberculous. So when talk about integration in Massachusetts this certain includes integration across HIV prevention and care, primarily, which will be the focus of my comments today, but also integration across communicable infections of public health importance and that impact vulnerable populations which are often the same group of state residents who are also impacted by HIV.

Dawn Fukuda: So for us in Massachusetts the idea of prevention and care integration made a lot of sense. Like one of my favored summer deserts, pictured here, it looked and sounded good, it seemed deliciously intuitive, and in many cases we could see, what were at the time, theoretical advantages of integrated prevention and care systems inclusive of planning and services and we actually had a really strong sense that it could work here in Massachusetts. And yet, and maybe this sounds familiar to those of you on the call, everything about the way we were set up at the time was fairly intractably siloed across HIV prevention and HIV care, both functionally in terms of factors like funding streams, CDC and HRSA in particular, the ways in which contracts were organized our staffing, our program locations, data systems, monitoring protocols.

Dawn Fukuda: And then, just as importantly, we were sorta culturally siloed in that these staff teams and planning bodies and community based programs where pretty much hardwired in different ways. And that is not and was not at the time a criticism because in truth these different perspectives and expertise and experience over decades is what often resulted in real synergies in the work and ensured complimentary advocacy and attention to both populations living with and at risk of HIV infection, which was a definite plus, but it also meant these folks were pretty passionate about and pretty protective of their distinct scopes of work and that included those of us at the Health Department. So we often

heard statements like the one pictured in the box at the bottom of the slide, I won't read them but maybe they sound familiar to some of you, too.

Dawn Fukuda: And so some of our earliest prevention and care integration conversations went a little like this: "You make a good point; we both hate the cat. I'm just not sure what it is you bring to the partnership." But ultimately we were able to identify some real integration champions among our own staff, among the providers we worked with and among individuals who interacted with our service system and were our clients and advisors and who supported some of the culture shifts and that helped other stake holders and staff with this transition and clarified some of the potential opportunities. Having an initial base of support among these groups, as small as their numbers may have been initially, was critical to gain momentum with our integration planning and integration activities as some of those efforts got underway.

Dawn Fukuda: So once we had some initial support and we were fully committed to moving ahead, and not, at that time, because we were under any federal funding pressures to accomplish prevention and care integration, at least we were not yet at the time, HRSA and CDC had not yet affirmed their support for that direction, which is now unified policy. So for us in Massachusetts, prevention and care integration actually started in mid-2011, over seven years ago, and it's really relevant to take note of the timeline because continuing theme in my comments will be that this integration process takes time. And I will never forget the moment I was sitting with colleague Barry Callis, who currently manages our entire integrated prevention, care, and population health advisory system, but then he coordinating our Prevention Planning Group, for those of you who remember the PPGs, and we turned to each other and we kinda said simultaneously "wait a minute, these are like the same people who participate in our HIV care planning meetings," or our consortia back then, "and sit on the party planning counsel and come to our state wide coordinated statement of [inaudible 00:17:52] for HRSA and are part of the household planning process and isn't there maybe a better way to do this?"

Dawn Fukuda: And at that point we spent a fair amount of time orienting and getting feedback from our planning bodies, initiating a formal process to dissolve the existing groups, and have closure with those members and groups, to thank them and recognize them for years of work in service in their different areas, and then implemented a formal application process to reseat a new integrated HIV advisory group. That process was followed by a significant amount of internal conversations and cross-training, of what was then the HIV Prevention and Testing team and the HIV Care and Case Management team, within the Office of HIV/AIDS, that was then followed by a formal structural reorganization in 2014. And finally a re-procurement of the entire contracted services system in an integrated framework which was only completed last year. And we are currently a little over nine months into the fully integrated system. So in truth, integration from start canal: seven years.

Dawn Fukuda: But before we arrived where we are today, shortly after we integrated our planning bodies, we really started articulating for ourselves all the potential benefits of prevention and care integration and Marissa actually highlighted some of these as well, not just in terms of planning but we also realized the amazing potential for public health impact that this level of integration would have if we could really meaningfully make it happen and that integration was also likely to have profound positive impacts for the ways in which populations we were charged to serve experienced funded services, making them more accessible and responsive, creating opportunities for one stop shopping, reducing stigma by expanding the breadth of services available in program settings, and we learned that we could consolidate staff with the types of expertise and cultural competence we need to address a range of client needs, irrespective of any diagnosis that they may or may not have and that uncoupling services and venues from HIV status, which also have some additional expectations for how you have to track HRSA funding through the requirements of Ryan White legislation, which is why there's a little asterisk next to that last bullet, prevented real opportunities. Plus the experience that funded providers had reduced reporting burdens, they had only one contract manager and one integrated set of performance expectations.

Dawn Fukuda: But, as you all know, because you do public health work, change is hard. And particularly for those of us for whom patience is not a personal virtue, so full disclosure, this is me. But I love how the little person in this picture emerges from the changing tent in a superhero cape, kinda inspires me. We were committed to integration in Massachusetts as a component of our strategic objectives, we knew that something needed to change for us to make progress in deploying new tools and leveraging new health care policies and to better reach existing and emerging priority populations both at risk and living with HIV or experience STDs and viral Hepatis.

Dawn Fukuda: So after what amounted to two years of intensive planning, cross-training, and information sharing, and many, many conversations with our human resources department, here at the Health Department, we were able to accomplish an office reorganization that is really now foundational to how we do our work. We moved from having three distinct administrative units over seeing a range of prevention and care services, to one unit overseeing all integrated prevention and care contracts and another unit, a new subdivision, focused on population health and community engagement activities.

Dawn Fukuda: So the new services unit was title Health Promotion and Disease Prevention Services, a little like what San Francisco did with their integrated unit, and again this unit coordinates contracted services across HIV, sexually transmitted infections, viral Hepatitis and tuberculosis, mostly tuberculosis infections or LTBI.

Dawn Fukuda: And the Behavioral Health and Infectious Disease Prevention unit that coordinates all advisory and community engagement efforts and designs and advises on population health services, such as drug user health and gay men's

heath initiatives, and other policy and program approaches to reduce health disparities.

Dawn Fukuda: So I won't lie, we continue to experience some collisions and intersections between these two scopes of work and we're still identifying where those opportunities to coordinate better are, but we have reached a point where integration efforts are working well and where the environment supports innovation and synergy between prevention and care efforts.

Dawn Fukuda: So some lessons learned on our journey, as Gene Roddenberry wrote, to explore strange new worlds and seek out some new ways of doing our work and I know you are all hearing the music in your heads. I won't read these points, I touched on them during my presentation but surface to say please do not try to rush this process or put pressure on yourselves or your systems to rush these processes, if at all possible, it is well worth the time and allowing people the opportunity to learn and absorb the rational for prevention and care integration and to have some positive first hand experiences with the process along the way. This will also help, we found, identifying and winning over others who will champion integrating message and the team make progress on different fronts.

Dawn Fukuda: In Massachusetts we actually started this whole process by spending a lot of time with our advisory bodies, bringing them together and listening to their concerns and hopes, this was a such an important and valuable upfront investment and really was foundational to each sequential step in the integration process. And just to underscore this is very much a step wise and gradual process and I'm sure the process will look different across our cities and states and territories and that obviously makes perfect sense. That said, I think there are great opportunities for peer to peer TA, like this webinar, across jurisdictions that are engaging in integration efforts and also within jurisdictions between agencies and planning groups and health department staff and others. We found that HIV prevention and care experts in the provider network and the community and within the health department were in a much better position to teach and support one another than we were to gather them all in a room and tell them how to integrate.

Dawn Fukuda: At the same time, I would tell my colleagues expect that things will go off the rails at some point. I have been accused in the past of being a glass half empty kind of person, so take that for what it's worth, but anticipate those challenging moments will come but also welcome them because they're a great learning opportunity and can help with course corrections, help get back on track. The other key lesson we learned in Massachusetts, and despite learning it early it has been one of the hardest steps to accomplish, is if you can to shed the old ways of doing business including the old words and old terminology, if they no longer make sense and if they don't support your integration goals. Massachusetts for example does not have a community and health department co-chair of our integrated planning body, our integrated planning group members do not vote or document [inaudible 00:25:12], medical case management and cure term health navigation services are delivered based on

an individuals equity level as determined by behavioral, psychosocial, or environmental risk, not their HIV status. And linkage engagement and retention and care is everyone's responsibly irrespective of funding stream.

Dawn Fukuda: These approaches have worked for Massachusetts and it may be that a different combination of steps and systems for different cities and states. We can attest to the fact that the integration effort was well worth the time.

Dawn Fukuda: So that's it for me. And thanks very much. And I will defer to the facilitator to ask the questions. I think I will pass off to my colleagues from North Carolina.

Robert Winstead: Thank you very much, this is Bob Winstead. I am the HIV Care Program Manager for North Carolina and that includes Ryan White part B and HOPWA services. And I am with my colleague Pete Moore who's the manager of our prevention program. And we are pleased today to share with you some information about our network model of service delivery, our process for integrating prevention, care and HOPWA services and also share some of the challenges and successes that we've seen.

Robert Winstead: So in North Carolina, we actually moved from a consortia model of service delivery to a regional network of care model in 2010. At that time we funded ten geographically defined networks of care, which included funding for Ryan White part B and HOPWA services. At that time prevention services were funded state wide but the funded prevention agencies were not affiliated with the networks of care.

Robert Winstead: In 2016 we issued an RSA to integration prevention services into our regional networks of care and those networks are now referred to as Networks of Care and Prevention. We currently fund 17 Ryan White, 10 HOPWA, and 39 prevention agencies across the state.

Pete Moore: So this is Pete, and I'm gonna talk about the process of adding prevention to our network model. It was a new system for prevention since we had previously funded all of our agencies directly, we've never funded our agencies through a network system and we thought that a lot of lead time was important for agencies, so we notified the agencies one full year in advance before we released our RSA.

Pete Moore: And after we notified them, all of our staff met with the RNCPs and the prevention agencies to clarify the process and get feedback. We outlined the process, how it was gonna go, the timeline, and then we did a Q&A session so people could kinda prepare themselves to participate in the new system.

Pete Moore: The next thing we did is we developed a funding formula. Prevention in the past had not funded based on a formula, so we didn't break it down based on geography or by disease we just had a RFA already supplied and we tried to balance it as best as we could throughout the state by geography and by disease

rates. So when we did develop a funding formula we had 60%hold harmless because a lot of agencies had built up pretty strong infrastructures and if we all of a sudden took that money away some of that hard line infrastructure would crumble. So 60% of the funds that we had allocated state wide we left as hold harmless per region.

Pete Moore: The rest of the 40% was broken down by, equally, 10% each, by census, by the number of HIV positive persons living in each region, by the average new HIV rate, and we did have 10% of our funding allocated for primarily, secondary, and early syphilis rates because in North Carolina our prevention program is HIV and STDs, so we wanted to make sure that STDs had a part in how we allocated money per region.

Pete Moore: We thought it was important to give people a good amount of time and leeway before we submitted the RFA. RFAs take about eight months to nine months from start to finish in North Carolina so we began ours eight months before it was supposed to come out. One thing we did is develop FAQs, frequently asked questions, we posted these online, we also emailed them to all of our agencies, and some of the main questions that people wanted answered were "How were funding decisions made? So we made sure to include our funding formula so it would be transparent as to how we funded folks.

Pete Moore: Another question was "do you have to provide prevention services in every county in your region?" And the answer is no, we wanted the regions to come up with their own plans on how they could best provide prevention services based on the need per county but not necessarily to allocate X-amount of prevention dollars per county, we let the regions make their own decisions that way.

Pete Moore: "How many care, prevention and HOPWA contracts were allowed per region?" We did have to limit that. We have ten RNCPs in North Carolina plus a TGA, the last thing we wanted to do was fund ten contracts in each region, we don't have the ability to manage a hundred contacts, so we did have to limit the number of direct contracts each region could apply for.

Pete Moore: We had to talk to them about how agencies subcontract. A lot of our agencies do get direct funds from the state and they have subcontract, we had to talk about how that structure could work and how those agencies would monitor their subcontracts.

Pete Moore: So we released the RFA in August of 2016, we had a bidders conference one week later and what we did then was we had a huge room open and we allowed everybody who's a potential applicant to show up where we reviewed the RFA and answered any questions for potential applicants to let them know what it would be like if they entered into a contract with the state.

Pete Moore: This next slide kinda is a timeline about how the process broke out. So you'll see in October of 2016 the applications were due. In November they were reviewed and funding decisions were announced. The contracts began in April of 2017 and ran into October of 2017 is when they began, they're staggered, with our HOPWA, Ryan White, prevention agencies, they all had different contract periods so they all began between April and October of 2017 and ended at different times.

Pete Moore: And then in May of 2017 we had a group initial site visit. So what we did then was we invited everybody that was gonna be funded through this RFA to a face to face meeting where we went over the process of contracting with the CD Branch with the state, covered fiscal and programmatic monitoring, what to expect when the monitor came out, and did a programmatic visit, what kind of fiscal monitoring they would be doing with him and what to expect in a fiscal monitoring site visit. Then we had Q&As, we allowed time for that.

Pete Moore: So how it works, kinda on the ground, is that our branch monitors monitor direct contracts and ensures that the agencies that have subcontracts monitor those subcontractors. Our monitors play a big role in disseminating information in guided RNCP process. All of our networks are required to meet at least on a quarterly basis and all of our monitors attend those meetings. What they do there is they provide information from the state to the regional networks and also bring information back to us with concerns that the networks might have about the process or about the work they're doing.

Pete Moore: It's important to note that all of our networks are very different. For instance, one has paid prevention coordinators, the other ones don't, nine of them don't have one person that coordinates prevention. But one of our biggest ones does and that makes things fairly easy. You have a lot of difference between rural and urban regions, they all have different resources, they all have different issues, for instance a lot of our larger networks have several agencies, CBOs and health departments vying for funds where some of our regions don't have enough, we have X-amount of money for some regions and not enough people to claim it, in some regions we have a lot of people that want that money that you have to go through a regional process to decide who's gonna get it and who's gonna be able to take part in the application.

Pete Moore: The last bullet is important to note is that all of our networks make their own decisions about who they include in their applications and really how they run their process. We don't prescribe as a state how a network is gonna make decision, they come up with that on their own and they all have really different decision making processes.

Pete Moore: So some of the challenges that we found in working through this process is some of the networks lost a lot of money based on the funding formula and then you have to negotiate that with them when they lose that amount of money they're not happy and you have to deal with it.

Pete Moore: We also wanted to make sure that our prevention agencies had a say in the process. As I think Bob mentioned earlier, the network model was something that our care agencies did for a long time. Two years ago was the first time we had put our prevention agencies into this model and we had to make sure that they were included, they had a voice at the table and the networks.

Pete Moore: I kinda mentioned this earlier, some of the smaller networks don't have enough agencies to do the work. So we had prescribed a set amount of money for them and we really had to work to do capacity build and TA to help health departments and CBOs be prepared to take on the prevention and care work, more so with prevention, I think, than care.

Pete Moore: And then another challenge is ensuring that the prevention, care and HOPWA agencies within each network collaborate to ensure that all the required and optional identified services were provided without duplication of effort and resources, there's a lot of work that goes on to make sure that you don't have FTEs that go above 1.5, you don't want to have two people, maybe one under prevention and one under HOPWA, both at .75 FTEs, obviously somebody can't work more than 40 hours a week so we have to compare staff to make sure that we're not duplicating efforts and that takes a lot of work and effort.

Pete Moore: So Bob is gonna talk about some of the successes that we found.

Robert Winstead: So as Pete mentioned there were some challenges and even though we've had some growing pains and challenges within the networks, we feel that the move to our integrated model of service delivery has been positive in many ways. When we decided to pursue this model of integration we did so because we wanted to make sure that we were integrating prevention, Ryan White, and HOPWA services within each of our network regions. And we wanted to make sure that our prevention, care and HOPWA service providers were communicating with each other and collaborating on service delivery in the regions and not necessarily duplicating services.

Robert Winstead: As a result of our move to this model we have found that each of our networks are better able to identify needed resources and services within their region and they're also better able to control resources and meet identified needs.

Robert Winstead: We also wanted to integrate our state prevention, Ryan White, and HOPWA staff to improve communication and collaboration among the staff. Prior to integration our staff had been separated, geographically if you will, we were all housed in different offices, and now we are co-located which facilitates better communication among staff.

Robert Winstead: We also were able to now make sure, as Pete mentioned I think, that prevention services were available in more counties than we had been able to serve in the past.

Robert Winstead: And we also found that prevention funds are now distributed more equitably across the state.

Robert Winstead: I mentioned earlier that our staff are now co-located, this has allowed us to, throughout our work day, stop down the hall and share with each other things that might be going on within a region involving not only prevention and care but HOPWA. And it also allows us to talk about agencies that were jointly fund. We have several agencies that receive prevention, Ryan White, and/or HOPWA funding, and one of our program areas may know of a problem or challenge that we need to address. So we can share those challenges and work to find resolution that works for everyone.

Robert Winstead: We also have joint staff meetings now. We try to hold those quarterly where prevention, care and HOPWA staff come together to just talk about the networks, identify any issues that might need to be discussed, and also to talk about best practices and share best practices that our providers have experienced within their network regions.

Robert Winstead: To take those meetings a little further, we also facilitate joint prevention care and HOPWA provider meetings. Those meetings occur two or three times a year and at those meetings we share information about prevention, care, and HOPWA services across the networks. We allow the networks and opportunity to present on successes and challenges that they have experience. We provide technical assistance regarding fiscal and programmatic issues as well. And I will add that each of our funded agencies is contractually required to participate in these meetings, that way we make sure that we have representation from each of our funded programs at the table to share in the conversation.

Robert Winstead: And our funded agencies also work with us in developing our integrated HIV prevention and care plan in state wide coordinated statement of need.

Robert Winstead: And I believe that's all we have. Pete, anything to add?

Pete Moore: No.

Robert Winstead: Alright, we'll pass it back to you then, Julie.

Julie Hook: Great, thanks so much, Pete, Bob, and Dawn, that was really, really interesting.

Julie Hook: So we have lots of time for questions and only a couple of questions have popped in so if anybody has any questions for either Dawn, Marissa, Pete, or Bob, please chat them into the chat box.

Julie Hook: Dawn I know you answered this privately back but I'm gonna repeat the question so you can say it to everybody. So one question that came in was "for full range case management regardless of HIV status, what other funding streams does Massachusetts utilize?"

Dawn Fukuda: Yeah, so thanks, and I'm sorry that I responded to Steve directly, but once we were able to accomplish fully integrated contracts we were able to set up separate budgets within those contacts to fund particular service types. So certainly for HIV positive people we can use HRSA resources but when we wanted to extend case management to people who didn't have HIV infections, we're using state funds in separate budgets, and sometimes we're able to use some CDC dollars, depending on what kind of services we're providing to at risk people, certainly lots of education, testing, linkage to care, can all be funded with CDC funds as well. It's just a matter of tracking those budgets and contracts, for us, to make sure that we can keep our HRSA funds focused on people with HIV infections.

Julie Hook: Great, thanks Dawn.

Julie Hook: Another question for you is "how has merging prevention and care affected stakeholder and consumer involvement?"

Dawn Fukuda: It's a great question and I think it was one of the things we were super worried about because, much like our providers, we had consumer and stakeholder groups that were very aligned to either prevention services or care services but once integrated those bodies we found that there was really a lot of synergy, it was very well received.

Dawn Fukuda: The other action we were able to take is we'd established a number of population specific, smaller advisory groups, so we have a transgender health advisory group for example, we have a Latino gay men advisory group which emerged out of other conversations, we have a drug user health advisory group which includes some individuals who are active drug users, people in recovery and providers who take care of them. So having one large integrated group actually created opportunities for these other, newer, very focused advisory groups that have also been pretty well embraced, so it was sort of a side effect of integration that we didn't necessarily plan for from the start but just happened.

Julie Hook: Great, thanks Dawn.

Julie Hook: We have a question for you, Pete and Bob, "Could you discuss the challenges and strategies of contract monitoring and site visits for contract funded with both the Ryan White, HIV/AIDS, parts A and B, and CDC prevention dollars?"

Robert Winstead: Yeah, this is Bob. So we, Pete and I, need to make a distinction here which is that even though we have integrated our networks of cares, our contracting is still separate, so we fund our Ryan White agencies separately from our HOPWA and our prevention agencies.

Robert Winstead: So we may have a sub-recipient that receives Ryan White and prevention funding but those contracts are separate and the monitoring process is separate. So we have not integrated the contracts themselves.

Julie Hook: Thank you.

Julie Hook: Next question, looking just to see if it might be better for Dawn to answer it, "What advice would you give to a region that has two different health departments, one that's over care and one over prevention and HOPWA, to try to integrate planning bodies and services?"

Dawn Fukuda: Wow. I actually don't think the strategies would necessarily be that different because even though we were one health department overseeing all of those services, the silos were pretty intense in many ways. We might as well have been different organizations.

Dawn Fukuda: That said, if you truly are completely different organizations, that may have completely different cultures and expectations and requirements and governmental affiliations, city or state, I think starting with conversations between those two organizations, often at the highest level possible. So for example, when we needed to advance work between cities in Massachusetts and the health department, we had sorta commissioner level engagements to city jurisdictional level equivalent mayor's office staff engagements, to sorta set the tone and then it was able to sorta get to the staff who were more approximate to the program administration.

Dawn Fukuda: But I would actually invite others on the call who've had more experience in that arena, Massachusetts doesn't, maybe to answer the question.

Stewart Landers: This is Stewart Landers, I'm part of the JSI IHAP TAC, I'll pick up on Dawn's response. I will add that there may be local or administrative barriers if they are separate health departments in terms of, for example, trying to integrate a planning body, the appointments process may be mandated to be separate and the reporting of the body may need to be separate.

Stewart Landers: So there may need to be different strategies that are maybe softer strategies in terms of communications, joint meetings, keeping people more updated on activities rather than more of the formal types of mergers that were discussed by all of the speakers today.

Julie Hook: Thank you Stewart for chiming in.

Julie Hook: Another question, maybe the folks from North Carolina can answer, "How do some recipients track clients served for funding stream in their reporting?"

Pete Moore: Yeah, Bob and I were just talking about that. We have completely, really separate reporting streams. So for prevention we have testing data that goes to

our state lab and then we have all of our agencies support a quarterly narrative that fills in any gaps that we don't get from our state lab and then Bob uses Careware for his HOPWA and his Ryan White reporting.

Robert Winstead: Yeah, we just had our HOPWA sub-recipients start using Careware last year, so it's still pretty new to them but we track all of our client services and that stuff through Careware. We have separate tracking for our funding streams for those two programs. So, that's how we do it.

Pete Moore: This is Pete again. A quick note. The state lab data that we get we do download clean and then submit through EVA-Web. So we do use EVA-Web but we have to go through our state lab to get the data first.

Julie Hook: Great, thank you. And Dawn I don't know if you have anything to add about that, how it works in Massachusetts.

Dawn Fukuda: Massachusetts is actually that same. We have a local installation of Careware and we also have data we submit vis-a-vis our state lab and it's through Evaluation Web, so it's very similar.

Julie Hook: Great. Thank you. So, just a reminder, so we're wrapping up unless there are any other questions. Scrolling through.

Julie Hook: So just a reminder that the slides from this webinar are already up on our website and that the recording and Q&A will be posted soon. Our next webinar will be later this month, on October 25 from 2-3 Eastern time on aligning local getting to zero ending the epidemic initiatives with integrated HIV prevention and care plans.

Julie Hook: And you can go to this link now and registration for this webinar is now open. So please visit our website to check out resources and archives and upcoming webinars or to join our ListServ. We have lots of resources and tools, including an integrated HIV prevention and care: an online resource guide. Which includes resources, tools and tips to support to the process of integrating HIV planning and implementation efforts across prevention, care and treatment delivery services.

Julie Hook: So please contact us again to obtain more information or request TA or to share your experiences with integrated planning or to join our mailing list.

Julie Hook: We thank you for listening in today. Have a great afternoon.