Julie: Thank you and good afternoon, everyone. Welcome to this webinar titled, Moving Integrated HIV Prevention and Care Planning Into action: Preparing for Integrated Funding. I'm from the Integrated HIV/AIDS Planning Technical Assistance Center, and I want to thank everyone for taking the time to be on today's webinar.

Julie: As health departments actualize their integrated plans, many jurisdictions are considering and attempting to integrate funding streams in order to facilitate greater integration prevention care services on the ground. The goal of this webinar is to provide information on what jurisdiction to consider as they start to think about integration of funding.

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

Julie: We'll be answering questions at the end of the call. We'll answer as many as we can as time permits, so if you have any questions, please type them into the chat feature. All questions including those that we don't address during the call will be added to a Q&A document and posted along with the transcripts and the slides, which are actually already available on our IHAPTAC page on the Target website.

Julie: 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 improve and inform future webinars and trainings. As a reminder the IHAPTAC is a three-year cooperative agreement that began in 2016 to support Ryan White programs parts A and B recipients, and CDC grantees and their respective planning bodies, with the implementation and monitoring of their integrated HIV prevention and care plans, and integrating HIV planning and implementation efforts across prevention care and treatment delivery system. The IHAPTAC is a partnership between JSI, HealthHIV and NASTAD. We provide national one-on-one chain training on how to get going on different integrated planned activities, how to publicize and disseminate the integrated plan and its activities to stakeholders, identifying roles and responsibilities for implementation, integrating HIV prevention and care at all levels, monitoring or improving your integrated plan and collaborating across jurisdictions.

Julie: \Now I'd like to introduce our speakers. Marissa Tonelli is a senior capacity building manager for HealthHIV. She leads HealthHIV's Three D HIV prevention program, the 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 programmatic decisions. She also provides support to the IHAPTAC on behalf of HealthHIV.

Julie: Mike Barnes is the community engagement coordinator at Washington State Department of Health. He oversees services for persons at risk for HIV which includes PrEP navigation programming, community based HIV/STD testing services, condom distribution, other HIV prevention services. Prior to his work in Washington Department of Health, he coordinated LGBTQ-focused youth sexual health education programs in both Seattle and Atlanta.

Julie: And also Karen Robinson is the HIV community program supervisor at Washington State Department of Health. She oversees HIV case management, housing, care navigation, and other community programs that provide services for people living with HIV. Prior to moving to Washington, she worked for local health departments in Iowa as the HIV program coordinator and in upstate New York as an HIV prevention specialist.

Julie: So now I'd like to turn the presentation over to Marissa.

Marissa: Hi everyone. Thank you, Julie, for that great introduction. As Julie mentioned, my name is Marissa Tonelli. I'm a senior capacity building manager at HealthHIV and I'm very happy to be partnering with JSI on the IHAPTAC. And my primary goal today is just to provide a brief overview of integrated funding and how it can align with those federal requirements, national goals, as well as your state's integrated HIV prevention and care plan. And as Julie mentioned, the premise for this webinar, is you might be considering integrated funding at your health department, which requires significant preparation and infrastructure changes at both your health department and within the community. We're really excited, I'm really excited to have Washington state here to really give a great peer example of how they are moving this model forward.

Marissa: So we know the national goal to end the epidemic includes four primary goals, the fourth of which is really most of applicable for our conversation today, and this goal is to achieve a more coordinated national response to the HIV epidemic. One way to do this is really by increasing coordination across federal government and federal agencies. So luckily for us, CDC and HRSA have really done a great job so far, beginning in 2015 by developing and releasing the integrated HIV prevention and care plan guidance, and this guidance really built upon the efforts to further reduce reporting burden and duplicated effort to streamline the work of health department staff and HIV planning groups and promote collaboration and coordination of use of data and and in the use of resources.

Marissa: One of the underlying goals of the integrated planning effort is to really leverage resources and improve efficiency and coordination of HIV prevention and care service delivery. I wanted to note here that we know the integrated plan is a living document. It really serves as the roadmap to guide each jurisdiction's HIV prevention and care service planning throughout the year and while you may have submitted your plan in late 2016, it will continue to be updated as we move forward in the funding cycle, and any efforts to integrate funding or integrate services should align with your integrated plan.

Marissa: So, why integrate funding is one of the questions here, and what we mean by this, there can be two different types of integrated funding. We're going to focus more on braided funding, but we wanted to provide an example of each. Blended funding really involves the commingling of funds into one pot, and the dollars can be drawn down for program needs. Unfortunately, that way, each of the funding sources loses its specific identity. So really for our reporting mechanisms and to allow for better tracking of funding, and allow us to meet the requirements of federal funds for reporting, braided funding is really the preferred model here, and this involves when multiple funding streams are used to pay for the services for an individual or a population, but a very careful accounting of how dollars are spent from each stream, so the funding source really keeps its identity

Marissa: Those who implement Ryan White and HIV prevention services already are familiar with tracking time and effort. However, this goes a bit beyond that, and braided funding can be a bit more complex. It might increase some fiscal tracking needs and it won't necessarily reduce the reporting burden. It may require some additional staff time and training to establish the infrastructure, but the benefit is largely that the administrative burden really happens behind closed doors and your clients are able to walk into an organization or services, receive an array of prevention and care services seamlessly. One of the other benefits of having just recently submitted your integrated plan is that you've already done a great job aligning many of your federal grant objectives for your two funding streams for both prevention and care services. But you do need to keep in mind exactly what funding streams can and cannot pay for the reporting and auditing requirements for each funding stream. And I also want to note that we must continue to advocate really with our federal partners for ongoing alignment of funding cycles and application requirements so that we can make this more realistic and reduce some of that administrative burden for health departments.

Marissa: So I mentioned why do you need integrated funding, some other reasons, and one of the reasons we need to do this is really to maximize the impact of very limited public funding, and also provide an opportunity to pull from several smaller sources, if you receive smaller amounts of funding from different federal sources and sustain new and innovative HIV prevention and care and treatment programs. This also will improve efficiency and effectiveness in meeting the goals and health outcomes of your programs and services that you deliver. So integrated funding also allows some more opportunities to integrate service delivery, which is great. And here are just some examples. Outreach and education for PrEP and HIV treatment, to supporting enrollment in health care coverage, can be integrated. Strengthening systems to deliver PrEP and HIV treatment and supporting medication insurance are just some of them.

Marissa: Integrated services funding can also really help maximize efficiency of resources and service delivery across infectious disease program, and this can happen through integrated surveillance systems and reporting systems, addressing individuals that are at risk for multiple infections or multiple co-occurring

conditions. It improves the efficiency of staff time and integration can also include mental health services, substance use treatment services, as well as housing and other support services. Aligning your integrated HIV prevention and care plans with goals to end the epidemic can really help to focus on improving health outcomes along the HIV care continuum and you can use the HIV care continuum to measure your progress. As I mentioned before, we want to ensure that your plan is a living document and that it evolves with the updated EPI and HIV care continuum data, and as the service delivery landscape changes with new biomedical approaches, opportunities, so leverage, integrate, expand funding, your plan should also evolve as well.

Marissa: I just wanted to provide one example before I key it off to Washington state, from the Massachusetts Department of Health and we will be hosting, this is a plug for our next webinar that we'll be hosting in the next couple of months, on changing your HIV program structure to reflect integrated HIV prevention and care services. The Massachusetts Department of Health is one health department that has done this already, which is housing, kind of their prevention and care programs in the same division. They've also already completed integrated funding of their HIV services and they integrate across infectious disease with [inaudible 00:12:13] and TD. So I just wanted to point that out and let you know that you'll be getting some information from JSI on our next integrated webinar. Without any more introduction, I will turn it over to Karen Robinson with the Washington State Department of Health to talk about their specific integrated funding model.

Karen: Okay. This is Karen Robinson and I oversee and supervise the HIV community programs on the care side, HIV client services at Washington State Department of Health. So I'm going to start with our strategic framework, and with giving you a brief background on how Washington went from creating an End AIDS Washington campaign to developing an integrated HIV care and prevention plan to then integrating our HIV prevention and care funding. End AIDS Washington got its start when a few community-based organizations started a community mobilization project. This resulted in the governor's signing an End AIDS Washington proclamation in 2015. In the End AIDS proclamation, the governor charged the statewide planning group with developing End AIDS Washington goals and strategies to achieve goals.

PART 1 OF 3 ENDS [00:19:04]

Karen: In developing this integrated plan, Washington decided to mirror the End AIDS goals and strategies. This made it as a continuous flow from End AIDS Washington into our integrated plan. While the End AIDS Washington focuses on wider investments that are needed across multiple systems such as the governor's office, legislature, Medicaid, the insurance commissioners, superintendents for public schools, housing, local health jurisdictions, and the Department of Health, the integrated plan focus was more on the delivery of prevention care and treatment services funded primarily by the Department of Health and the Seattle TGA or public health.

Karen: In the integrated plan and End AIDS Washington there are five goals and 12 strategies. The five main goals are reduce by 50 percent the rate of new HIV diagnoses, increase to 80 percent the percentage of people living with HIV who have a suppressed viral load, reduce by 25 percent the age adjusted mortality rates among people living with HIV, reduce HIV related health disparities among people living with HIV, and improve the quality of life among people living with HIV. Our aim is to reach these goals by 2020.

Karen: So the 12 strategies in the integrated plan are to reduce stigma, community mobilization of persons living with HIV and persons at high risk and black and Hispanic communities, implement routine HIV screening, increase access to transmission barriers including PrEP and condoms, improve healthcare for sexual minorities, improve prevention and care for substance users, reduce insurance barriers for people living with HIV and persons of high risk, increase housing options for persons living with HIV, and then increase persons living with HIV and persons of high risk engaged in comprehensive healthcare, improve sexual education, provide community engagement for people at high risk and people living with HIV in HIV communities. And then we added in the last year [inaudible 00:16:38] to care as another strategy.

Karen: This is a very busy visual. It is the one that we use in order to illustrate Washington's overarching goals, strategies, and the corresponding activities and how they fit into our integrated plan. We also use this when we are making funding decisions and they drive staffing as well as funding decisions in our department.

PART 2 OF 3 ENDS [00:38:04]

Karen: Okay. So why did we transition to integrated funding? There were three primary reasons why we decided to integrate HIV prevention and care funding. The first reason was client engagement. The routes to antiretroviral therapy for persons living with HIV and PrEP for persons at high risk have similar obstacles and similar goals, those goals being retention and adherence. By using a mix of state, federal and local rebate funding, we would no longer have to limit the populations we serve by funding source. Our community services portfolio would be a comprehensive system of services that would meet the needs of both at risk persons and persons living with HIV regardless of income, intensity of need, and geographic residence.

Karen: The second reason was economies of scale. By serving both at risk persons and persons at high risk in a single HIV community services portfolio, we could reduce the cost associated with maintaining separate systems of prevention and care, including funding separate workforces with similar skills. Acuity models would make it possible to provide low and moderate level services to persons with routine needs and since these system typically cost less, we felt we could free up higher skilled workers to focus on individuals with more complex needs.

Karen: The third reason we decided to transition to integrated funding is to better align services and systems. Effective collaborations are essential to expanding service delivery and support of increased antiretroviral use ...

Karen: Expanding service delivery in support of increased anti-retroviral use among persons at high risk, and persons living with HIV. To reach the increasing demands of our HIV community services portfolio, we felt we could strengthen partnerships with our traditional partners, and establish new partnerships. These partnerships would include both public health, clinical care, community based organizations, and Medicaid and health insurance.

Karen: Okay to accomplish the integration of a care and prevention funding, we needed to develop a funding opportunity. So we wanted to release an integrated request for an application to do this. So in 2015, with an initial white paper that outlined the reasons for integrating HIV prevention and care funding, client engagement, economies of scale, and alignment of services and systems, we started the process. The goal of the white paper was to get community based organizations, clinics, and local health jurisdictions thinking about integrated funding and programming. We wanted them to think about how they could more fully implement integration in their own agencies. We wanted existing care and prevention planners to think innovatively and creatively, and we wanted to tap into additional players who had not been part of HIV work in previous funding announcements.

Karen: Our next step was to release a concepts paper. Released in 2016, the concepts paper was essentially a more nuanced version of the initial white paper. In the concept paper we firmed up some of the more amorphous ideas, and eliminated those concepts that were idealistic or unachievable. Shortly after releasing the concepts paper, we released the request for applications for funding that would begin January first of 2017.

Karen: As a result of the request for funding, we had 16 successful applicants. Of these applicants, six agencies were funded to provide care services only, four agencies for prevention only, and nine ... oh I had this wrong, I'm sorry. In 2017 we started seven agencies were to provide care only, two agencies were funded to provide prevention services only, and seven agencies were funded to provide care and prevention services. For the 2017 funding cycle, prevention service funding was only available in primary and secondary urban areas where there was a highest prevalence of cases. And this is the primary reason why six agencies only received care funding, and not prevention funding.

Karen: While funding streams were not integrated in all agencies, DOH encouraged strategic partnerships between care only or prevention only agency, and cross agency programmatic collaborations. With DOH only funded care services or always funded prevention services, it was with the understanding that agencies with both together to provide a full spectrum of prevention and care services.

Karen: In 2018 with the addition of additional state resources and programmatic success agencies that received integrated funding, the HIV community services portfolio increased to 19 contract, six were care only, four receiving prevention funding only, and nine agencies providing care and prevention services. So this increased the number of agencies funded from 16 to 19. In addition, in 2018, DOH is funding a cross agency collaboration between a community based agency, a local health jurisdiction, and a medical clinic, to provide a max clinic. The max clinic will serve high acuity persons who are at risk for dropping out of care.

Mike Barnes: all right, hi everyone, this is Mike Barnes. I'm going to be jumping in here for a little bit, Karen will be back in a bit. This next slide is showing the types of services that are funded for persons at high risk, and for persons living with HIV. You could see here the key services for persons at high risk include things like community engagement, outreach, testing services, as well as early intervention services and the four components that go along with that. On the persons living with HIV you can see this includes kind of the hard to define categories, including case management and housing, and all that good stuff.

Mike Barnes: We found the main opportunities for programmatic integration really in the early intervention services, and with our navigation services, kind of for prep, as well there are navigation services for people living with HIV. What you can see here is like the overlap in the services. The required components of EIS very closely mirror many of our kind of traditional prevention services, while prep navigation shares many qualities as case management services for people living with HIV. Another important thing to note here is that for our prep navigation services and our peer navigation services for people living with HIV, a lot of the tools that were developed for case management services for persons living with HIV were kind of used to develop those systems, and that work.

Mike Barnes: So I know this slide is a little busy, but I'll walk you through it. On the prevention side of things, one of the first things that we did was really pull all of our funded partners together to begin to talk about what we were framing as kind of a paradigm shift in our prevention work, brought on primarily by the move to increase PrEP navigation services, which we really see as a service that required an approach more similar to case management, than a kind of typical shorter term prevention services and interventions. So the first six months of our contract period was really spent collaboratively building our new kind of prevention services portfolio, which required a lot of collaborative planning where we developed prevention specific service definitions, talked about data systems, key data points we wanted to collect related to prep navigation.

Mike Barnes: And while we were sure to kind of keep our traditional prevention, like [eptos 00:25:48] in our mind as we were having these conversations, the shift to navigation services really required more strategic state wide coordination and standardization than the previous funding cycle. And I think our funded partners really did recognize this. I feel like this may feel a little counterintuitive to the integration conversation, you know pulling all of our prevention partners aside

in one room to talk through this stuff, but the paradigm shift on the prevention side of the equation really required all of us as prevention staff, to get on the same page before we move forward, really thinking about integrating with the care side.

Mike Barnes: I will say in these conversations we did have care staff from DOH that were present to really help us think through some of the emerging prevention ideas we had, with services that care was already funding and continuing to fun on the care side. I think a good example of this, we identify care ware as a potential database for our PrEP navigation services, to help assist in some of the client tracking and follow up work. And through those conversations care staff were really there to support prevention staff in learning more about care ware and how it could be adapted to meet the needs of our PrEP navigation programming. And I think the embrace of this prevention paradigm shift was really a key element in being able to more fully realize opportunities for future programmatic integration efforts with the care side.

Mike Barnes: And the illustration above really just kind of outlines our pre integrated RSA prevention activities on the left side, kind of moving along what I refer to kind of as our continuum of program guidance, but I also kid of read that as the state wide coordination and standardization of prevention focused activities. And it was kind of this framing that allowed us to have these conversations with prevention partners in the first year of our integrated contracts.

Mike Barnes: In preparing the community, I think it's important to note that this doesn't mean that you're going to be able to, or we were able to circumvent all the barriers to integrating funding and programming, and it really is not easy to anticipate some of the barriers that do pop up. But during the development of our RSA, I'll start with kind of the community engagement piece here. Community engagement throughout the process was really vital. And as Karen said, we started with our white paper, we moved on to the concepts paper, and then finally the kind of actual RSA document. And as we went through this, it was really important to get our interested community base and local health partners thinking about integrated funding before releasing the RSA, and really begin to think about what integrated funding and programs would look like at their own agencies before responding to the RSA.

Mike Barnes: So we went through the white paper and we went through the concepts paper. We hand a number of different community forms and webinars to get feedback from community, and this feedback really did change a lot of our thinking as we kind of moved through those three documents. The planning bodies, there's of course coordination across planning bodies is very important, and I'll talk about that on the next slide, so I'll jump over to that real quick. And then finally another important thing was really making sure that health department staff were available for technical assistance, when implementing integrated contracts, particularly as agencies are working through integration at their own agency on both the funding and programmatic front. And for us, this meant doing more face to face work with folks, being on site, doing meet and greets

with funded partners that were really separate from kind of our regular quality assurance calls or program monitoring, or contract monitoring. So just more of that face to face time was important.

Mike Barnes: Like I said, integrating and having planning bodies working together was really important. And for us, we have our state wide planning body, which we refer to our HIV planning steering group, and they've really worked to coordinate the development of the integrated plan. Working closely with the Seattle part A planning counsel, they've created parts of the plan related to the part A services within the Seattle TGA, that then the state wide planning body coordinate and built into the state wide plan. The part A planning counsel also gave input into the end Aids Washington recommendation, which we mentioned previously, so those feedback loops were happening. And multiple members of the state wide planning body are also members of the part A planning counsel, which really allows for ongoing kind of coordination around state wide and part A planning activities, which is really important.

Mike Barnes: In coordinating service delivery, the state department of health here, they fund our ADAP program, out PrEP drug assistance program, case management services for people living with HIV, peer navigation services for people living with HIV, PrEP navigation services for persons at high risk, as well as other prevention services around the entire state. Part A funds supportive services for people living with HIV within the TGA, and then the state department of health helps fund supportive services for people living with HIV outside the TGA. So that's how service delivery is coordinated between the state and our Seattle TGA.

Mike Barnes: And then the shared data system, I'll talk a little bit more about this in a couple slides as well. But some recipients funded by Part A, and through our HIV community services RSA for both care and prevention services use the same data system. So this is currently Care Ware, but we are moving to provide enterprise as we begin to enact centralized eligibility, and really work to build a more comprehensive shared state wide database. And again, this includes our Part A, this includes our PrEP drug assistance program, and this includes our HIV community services partners who are providing services for both prevention and care sides of the equation. And the one thing I'll say here as well, HIV testing data is still being entered into evaluation web, so our par partners, or those doing prevention activities around the PrEP navigation and the testing work, are still working out of two data systems, and are kind of for the foreseeable future.

Mike Barnes: The transition to a new data system to provide has really been a truly collaborative process, with kind of all partners at the table from the very beginning, which has been really awesome to get us to think a little bit more critically about how a shared data system could really impact integration. We have not implemented provide yet for all of these different stakeholders, so perhaps next year we can maybe do this again and talk about how the implementation actually went. We're hoping it goes super great.

Mike Barnes: So lessons learned from this process, I will walk you through these. So I've mentioned previously, there's no way to really circumvent all the barriers and challenges that you're going to encounter as you go through integration, on both the funding side and on that programmatic side. But some lessons that we did learn, really regular and consistent communication is key to building relationships, both internal to our state department of health, but then also with our external funded partners. And some of those other partners, Karen talked about who are part of a larger End Aids Washington umbrella. So really looking for opportunities to get integrated agencies to have their care and prevention teams interact more has been really important for us at the state level.

Mike Barnes: So some of the things that we've done is like integrating our quarterly reports, building prevention activities into the already existing quality management activities on the care side, doing integrated partner check ins, so having care and prevention staff be on the same calls. And we're kind of talking about the work that is being done on each side respectively. And again, those meet and greets, making sure they involve both prevention and care staff, so folks are getting together and they're talking to one another. And this exists at the state level too, right? Barriers to communications between our care and prevention staff here. Sometimes our teams feel physically separated. We are all in the same building, but we're kind of in different sides and different blocks of cubicles. We have different managers coordinating prevention and care staff. Our state is really embracing an alternative workplace environment, so some folks aren't necessarily in the office as regularly.

Mike Barnes: So one question that we really have to kind of continuously ground ourselves in is how we're maintaining regular and consistent communication between staff on the prevention and care side. And I think if we ask ourselves that question, it also helps us to kind of reflect on our funded partners who are getting both care and prevention funding, because they're going through the same thing, and they're having a lot of the same questions about what this looks like at their agencies.

Mike Barnes: In regards to finding common ground between care and prevention services, through our process it really became clear that prevention, just given the lesser amount of funding, had more work to do in aligning with care services. Many prevention staff, I think, were prepared and excited to take on some of the new navigation work, but this really wasn't the case for everyone. And I think we know a lot of those barriers around increased data collection efforts, and doing more routine client follow up on the prevention side, and a more standardized approach to navigation services was a struggle for many to fully adopt, and that's still something we're working through to improve here.

Mike Barnes: I think it's really important to look for opportunities for care staff to help prevention staff really learn about the services happening on the care side, and about their respective approaches to the work, and really vice versa as well, right? Having care staff help prevention staff learn about a more case

management approach to client level work, things like data collection and input, client follow up, using data tracking systems, things that historically had not been used on the prevention side. And then having prevention staff help care staff learn more about things like outreach and engagement activities and things like that.

Mike Barnes: Another piece of this is, really don't underestimate the value of peep to peer technical assistance. I think as an example, like I said, some of our prevention partners really struggled to take up the PrEP navigation work, while others really thrived doing the work. So those who thrived have really helped to elevate the work for some of those finding it more challenging. Just as an example, we had care staff from one agency cross training prevention staff from another agency, and using Care Ware in King County, and it's those opportunities I think are really important and kind of awesome to see organically happen.

Mike Barnes: Considerations, so we integrated funding through integrated contracts, and I think truthfully that is the easiest part, right? We integrated the contracts. Programmatic integration has really posed many unique challenges, but when we're thinking about contracts and invoicing, it can make programmatic integration more challenging, so it's important to realize how closely linked those things are. I think a perfect example, maintaining separate staffing for care and prevention activities for billing purposes is really a lot easier for a lot of our contracted partners. And this is a product I think one of how invoicing works at the state department of health here, but also a lot of the reporting requirements for different activities determined by the funding stream complicates it as well. But we really believe that this kind of integration of staffing is really key to maximizing resources, like we outlined earlier. so as you're going through, I think it's really important to consider how documentation and invoicing can really impact the ability of some recipients, to fully realize programmatic integration with the work that's happening on the ground.

Mike Barnes: In relation to contracts, many of our partners expressed a challenge in kind of having too many state department of health staff to reach out to, depending on kind of what question they had, whether the question related to people living with HIV, or persons at high risk, or was it related to invoicing. So we worked to kind of create a kind of single point of contact at the state. And for us, this looks like-

Mike Barnes: Point of contact at this stage and, for us, this looks like an email box that our prevention staff and our care staff have access to that would ensure, kind of, coordinated responses to our subrecipients. So that one answer wasn't coming from one person and another answer from another person. That really gets confusing, we don't know who said who to what.

Mike Barnes: So that was kind of our challenge to work through and we'll still working to develop those processes as well. In relation to, kind of, the silos in our work ... another invoicing challenge is really just the diversity of different funding

periods we were working off of, depending on the funding stream. And this has proven really challenging to navigate both internal to the State Department of Health, as well as for our partner.

Mike Barnes: I think a perfect example is our state fiscal year is running July 1 through June 30th. The other HIV community services contracts are running January 1 through December 31st. So while our agencies are looking at spending on one timeline, right? They're thinking, "Oh, I have a whole year to spend out these funds." At the state level, we're kind of looking at it like, "Well, we want you to be spent by 50% across all line items by the time you hit July 1, right?" So, it's just kind of looking at it from two totally different perspectives.

Mike Barnes: My last slide here is gonna be around next steps. So I think next steps for us is really continuing to be available for our funded partners to provide technical assistance. But like I said before, really emphasizing peer-to-peer technical assistance with agencies that's embraced integration. Working to share best practices with other partners who've been a little slower to take. On the, kind of, data system side we really want to continue our provide transition and really work to go from many data systems down to one per all partners across the board.

Mike Barnes: I think that we implement provide for people living with HIV and for person high-risk programming across the state. We either continue to be on the lookout for how that can enhance problematic integration. I think care really drives the choice of data systems, it's where the money is and where the primary amount of services are happening. And in prevention, we kind of figure out ways to make it work.

Mike Barnes: But, soon as provide transition we really have been trying to elevate everyone's voices through the process to make the data system that works for all parties across the board, more or less more equally. And then in regards to standards, we've really been working to continue to integrate statewide guidance documents that are inclusive of both our services for persons at high-risk, as well as people living with HIV.

Mike Barnes: And, with that, I'm actually gonna turn it back over to Karen for this last slide.

Karen: Okay. This last slide is actually ... I pulled it from our integrative plan and it really summarizes the benefits gained by integrated HIV cure and prevention funding. Synergy is the interaction of two or more agents to produce a combined effect that is greater than the sum of their separate parts.

Karen: So, even with some of the obstacles we've faced and some of the paradigms we've had to shift we certainly have enjoyed a greater effect by working together on this project. So, that's all.

Mike Barnes: There's our contact information in case anyone has any questions or anything. But with that, we will pass this back over to Julie for some Q&A.

Julie: Great, thanks Marissa, Mike and Karen that's a really interesting conversation. The questions have come in but if you have any additional questions for me or our presenters, please type them in the chat box.

Julie: So, first question for Washington, Karen and Mike, "What funding sources were included in your funding opportunities. Did it include a combination Part A/B prevention and rebate funds?"

Julie: Can you talk a little bit about what was included in your funding opportunity?

Karen: The RSA included Ryan White Part B funds, included our rebate funds ... it included CDC prevention funds as well as state generated funds, from the state. So it gave us a wide ... breadth of opportunities on how to fund different activities or different populations.

Mike Barnes: Yeah, for prevention activities it was mostly state funds with some CDC funds but the CDC funds but the CDC funds that we allocated through the RSA were limited.

Mike Barnes: So that is the privilege we have at Washington State Department of Health, that we have some state funds to play around with.

Karen: Right and for the care funds, it was primarily the rebate dollars in the first year. The second year we have gone ... we are using more of the Ryan White based award funds.

Julie: Great, thank you. Another question is, "Could you talk a little bit about how the research allocation and service prioritization process works, including how the planning house of the TGA maintained its authority while working in partnership with the state and community planning groups?"

Karen: Okay. Well, one team on the care side decided a number of years ago that the state would actually fund case management for the entire state including the TGA. So, that made it possible to have one set of standards ... the state also administers the Medicaid Title 19 targeted case management so we were able to use one set of standards, one set of monitoring tools and quality measures across the state with our case management services.

Karen: And, we are carrying that forward into our peer navigation services that peer navigation will be funded primarily through the state's health department. That allows the TGA to use their funds to do their supportive wrap around services and that's where their autonomy comes in.

Mike Barnes: And I would say, on the prevention side ... very similar processes are before we directly funded with DOH ... DOH directly funded our non-King county CBOs to do prevention work. And in King County which is where Seattle is located. Public Health - Seattle of King County funded the CBOs there with passed through funds so it kind of created two separate systems there of a local health jurisdiction overseeing a number of contracts there and the State Department overseeing a number of prevention contracts across the state.

Mike Barnes: And through this RSA process we again had the state distribute all of the funds directly to all of the CBOs statewide. It was again the standardization and coordination of services made it a lot easier to do it that way.

Julie: Great. Another question for Karen and Mike were, "Does subrecipients that provide both co-located prevention and cure services, prioritized for funding?"

Karen: I'm trying to think back. When we reviewed the-

Mike Barnes: Yeah.

Karen: ... the RSAs. We basically were looking to make sure that every county was covered with service ... had services and so, it depended a little bit on where the funding application came from in terms of prioritizing that. The other thing we were looking for was willingness to work together on projects. We fund quite a few ... the case management agencies, we have four that we fund in the Seattle PGA and in those cases we wanted to make sure that anybody that was getting funded for care only or prevention only in the TGA, that they were hooked up in a way that there was a continuum of care represented with their clientele.

Karen: So, I can't say that we've necessarily prioritized those that were co-located but we certainly, in contract negotiations, discussed it heavily.

Mike Barnes: Yeah, again, I think it was more geographic based is what determined our decision and I think we did have to have some hard conversations about folks who did apply to say, do case management services for people living with HIV who had historically only done prevention services. In thinking about how many agencies within a particular county were providing case management services and whether another agency who wanted to get into the game, really ... the amount of work it would take to build a case management from the ground up was something that was discussed.

Karen: Yeah.

Mike Barnes: I think those were, for example in King County where we have some agencies doing only care services and some only doing prevention. But really encouraging them to work really closely together to kind of almost look at it as a cohesive system of prevention to care. But just housed within two different agencies, but closely located near each other and providing services within the same county.

Karen: Right. And for our 2018 contracts we actually did move some prevention funds into agencies that were able to target foreign born Latinx that were outside of the primary CDC defined prevention areas. That was one of the things that we worked as a separate project outside of the RSA, in the second year of funding.

Julie: Great, thank you. Another question about ... for you Karen and Mike is, "What are your monitoring activities mostly like for those integrated funds?"

Karen: Okay. We have quarterly reports that we monitor. We do traditional site visits some of those are monitoring visits we use our standards of care that we've developed for both care and prevention in order to monitor whether our agencies are following the standards of care.

Karen: We have our quality improvement activities that we also are looking at. That they ... all agencies have a quality improvement goal that they've set in their contracts. And then we do a lot of face-to-face meet and greets where we go out and just talk to 'em when we're not monitoring them and that seems to be a really positive way to build the partnerships with our agencies.

Mike Barnes: Yeah, and of course we're running CAREware data for PLWH. We're also CAREware data for our Pratt navigation work from CAREware and then EvaluationWeb, obviously for HIV testing, we're running reports from there to monitor HIV testing deliverables.

Karen: Yeah.

Julie: Great, can you also talk a little bit about you've handled three different grant years so, CDC, Ryan White, state and devising their contract copy periods and one funding cycle ends within the contract year?

Karen: Yeah, that's been a little bit of a ... it's been one of the obstacles of ... the way we run it is we win their contracts, we set up buy funding source when the funding period ends so if it's Ryan White Part B, their January through March is actually in a different Ryan White fiscal year than it is after April and so we just break out the contracts and look at, "Okay, so that needs a fourth of the time and something we may end in July so that's a 50% of what funding they need and then another part is 100%, so we have very complicated contracts that go out the door and then we work with our fiscal people in our agencies to help them understand what we're doing and why we're doing it.

Mike Barnes: We're working through it.

Karen: We're working through it. We're thinking about moving our contracts that start January 1st to starting July 1st so that they're all running on the state fiscal year and then trying to figure out all that other stuff around it right now so it's ... there's a lot of spreadsheet. I'll put it that way.

Mike Barnes: Yeah, we haven't figured out any easy solutions so if anyone has, feel free to let us know 'cause we're looking for some new ideas.

Julie: Great, there's a few more questions. If you guys don't mind answering a few more.

Julie: "So how do you coordinate your Part A rebate and prevention with the TGA's part A funds?" So are there any plans to integrate with Part A?

Karen: We work really closely with Part A, as I said, we do fund all the case management services across the state whether it's Part A or not. And, we also have Part A funds in one county in the south of the state in Clark County with the Portland TGA. So if we have ... if there are funding needs in the Part A area we work with the Seattle TGA to make sure that we are not sub planning any of their funds or that if they have a need and they want additional funds, or need additional funds. For example, they run a MAX clinic out of Seattle, we will use some of our rebates to fill in some of those gaps. It's mostly that we have, it's just a very active partnership with our Part A partners to work through some of those issues.

Julie: Great, and you may have mentioned this but do you ... I'm sorry if I'm repeating something but do you pass CDC prevention funds to King County?

Mike Barnes: Yes.

Karen: Yes, we do.

Julie: Great.

Mike Barnes: Yeah, they go to Public Health - Seattle King County, they do not go to our community-based agencies in King County.

Julie: Great, well thank you Mike and Karen for telling your story, and a lot of really interesting information, so we thank you.

Karen: Okay.

Mike Barnes: Thank you.

Julie: So the slides to this webinar are already up on our website and the recording and we will also pull together the Q&A for people to be able to review as a PDF document. That will be posted soon and as Marissa mentioned in her opening slide, we have an additional webinar coming up this summer as part 2 to this webinar that sort of looks like whether the practical changes within the health department that needs to happen integrate delivery and prevention and care services, so please stay tuned.

Julie: Please visit our website to check out our Integrated HIV Prevention and Care Plan online resource guide. Included in this guide are resources, tools and tips to help inform and guide the work of jurisdictions in the process of integrating HIV planning and implementation efforts across prevention, care and treatment delivery services.

Julie: As part of this online resource guide, we have help with assisting implementation efforts, we've identified some strong plan sections for a number of jurisdictions that can help you form ongoing implementation and improvement of Integrated HIV Prevention and Care Plan activities. So please take a look at our website, the Target Center website for additional information.

Julie: And please contact us for any additional information, to request TA or to join our mailing list.

Julie: I want to thank everyone for listening in today. Have a great after-

PART 3 OF 3 ENDS [00:55:34]