Integrated Planning Activities for Prevention and Care: Best Practices and Lessons Learned

Thursday, April 25
3:00 – 4:00 PM ET

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About the IHAP TAC

3-year project

began
July 1, 2016

Supports

Ryan White HIV/AIDS Program Parts A & B recipients and their respective planning bodies with integrated planning including implementation of their Integrated HIV Prevention and Care Plans

Conducts national & targeted

training and technical assistance activities

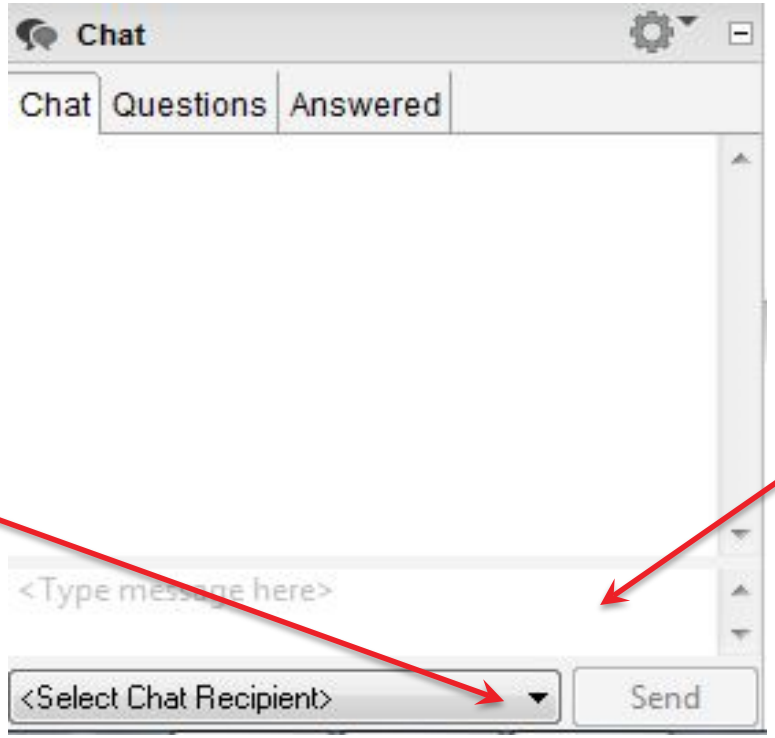
Support Available Through the IHAP TAC

- **Integrating HIV prevention and care** at all levels
- **Strategies for implementing** Integrated Plan activities
- **Publicizing and disseminating progress** of Integrated Plan activities to stakeholders
- **Identifying roles and responsibilities** for Integrated Plan activity implementation
- **Monitoring and improving** Integrated Plan activities
- **Collaborating** across jurisdictions

Chat Feature

If you have questions during the call, please use the chat feature. To do so:

Use the drop down arrow to send your comments and/or questions to "Broadcast to All"



Chat comments and/or questions here, and please indicate which jurisdiction you're from.

Webinar Objectives

Following the webinar, participants will be able to:

1. Describe types of integrated planning activities that jurisdictions can pursue.
2. Understand the rationale and benefit of integrating planning activities of prevention and care planning bodies.
3. Describe practical strategies to successfully implement integrated prevention and care planning activities.

Today's Presenters

Molly Tasso

IHAP TAC Technical Assistance Coordinator

Parrish Oglesby

Planning Manager, Memphis HIV Care and Prevention Group

Mark Molnar

Program Director, HIV Community Planning Council, San Francisco

Audience Poll

Have you been on an IHAP TAC webinar before?

- Yes
- No

Overview: Health Resources and Services Administration (HRSA) & Center for Disease Control (CDC) Planning Bodies

Molly Tasso

IHAP TAC

HIV Planning and Community Input

- HRSA and CDC require HIV planning processes involve community stakeholders
- Community stakeholders include people living with HIV (PLWH), vulnerable populations, HIV service providers and others affected by HIV
- Goal of community involvement is to enhance coordination, collaboration, and seamless access to prevention, care, and treatment services

HRSA Requirement

"All CDC/Division of HIV/AIDS Prevention (DHAP) and HRSA/HIV AIDS Bureau (HAB) funded jurisdictions (the 50 states, Ryan White HIV/AIDS Program (RWHAP) Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes … the establishment of either an HIV Planning Group, Planning Council, or Advisory Group."

-Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017- 2021

RWHAP Part A Planning Councils

- Legislatively required to establish a Planning Council/Planning Body (PC/PB)*
  - Independent decision-making body that reports to CEO and works in partnership with recipient
  - Membership composition is legislatively mandated (including 33% representation from unaligned consumers of RWHAP Part A services)
- Responsibilities (required for PCs) include:
  - assessing needs of local PLWH
  - setting service priorities
  - establishing resource allocation decisions
  - developing service directives

* Section 2602(b)(1-6) of RWHAP legislation

RWHAP Part B Planning Groups

- RWHAP legislation requires Part B recipients to engage in a "public advisory planning process"*
  - Grantees may choose to manage Planning Groups internally or establish Consortia (outside planning group)
- No legislative requirements related to roles, responsibilities, or composition
- Planning group is advisory and decisions/recommendations regarding allocations are not binding.

* Section 2617(b)(6) and (7) and Section 2613 of RWHAP legislation

CDC Division of HIV/AIDS Prevention-Funded Jurisdictions

- PS18-1802 funds all 50 state health departments, Washington D.C., Puerto Rico, and U.S. Virgin Islands to implement integrated HIV surveillance and prevention programs
  - CDC also directly funds seven local health departments
- Awards support two central CDC priorities
  - Ensure that all PLWH are aware of their infection and successfully linked to medical care and treatment to achieve viral suppression
  - Expand access to pre-exposure prophylaxis (PrEP), condoms, and other proven HIV prevention strategies for people at high risk of becoming infected

CDC Jurisdictional HIV Prevention Planning Groups

- Health departments are required to establish an HIV Prevention Planning Group (HPG)
- Comprising community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services
- HPGs are responsible for informing the development of the Integrated HIV Prevention and Care Plans
- HPG is an advisory group and does not allocate fiscal resources

Integrated HIV Prevention & Care Planning Activities

Current State of Integrated Planning

- 38 states and Washington D.C. now have integrated prevention and care statewide planning bodies
- More than 25% of RWHAP Part A EMA/TGA jurisdictions have integrated prevention and care PC/PBs

Rationale for Integrating Planning Activities

- Reduce reporting burden and duplicative efforts by recipients
- Streamline the work of health department staff and HIV planning groups
- Promote collaboration and coordination in the use of data for prevention and care program planning, resource allocation, evaluation, and continuous quality improvement efforts

Integrated Planning & the HIV Care Continuum

- Integrated planning allows jurisdictions to engage in planning activities with a ‘treatment as prevention’ philosophy
- Promotes a more coordinated and comprehensive response to the epidemic in jurisdictions
  - Integrated planning can address the entire continuum from diagnosis to linkage to care to viral suppression

Types and Levels of Integration

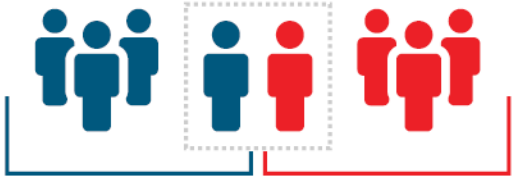
- Jurisdictions have different options available when deciding to undertake integration of prevention and care planning
  - A fully unified or merged prevention and care planning body is *not* 1) feasible for all jurisdictions or 2) the only ideal approach to integrated planning.
- Jurisdictions are encouraged to explore different types and levels of integration
  - Determine which model will best suit unique needs of each jurisdiction
  - Integration is an ongoing process and level of integration can be intensified over time – no need to rush the process!

Information Sharing

Cross-Representation

Integrated Information Gathering and/or Analysis

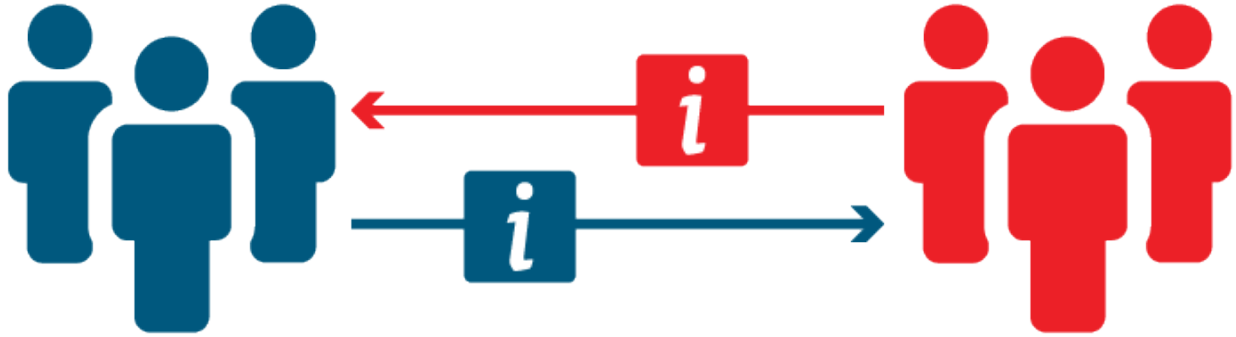
Integrated Committee of a Larger Planning Body



Unified Prevention and Care Planning Body

1. Information Sharing

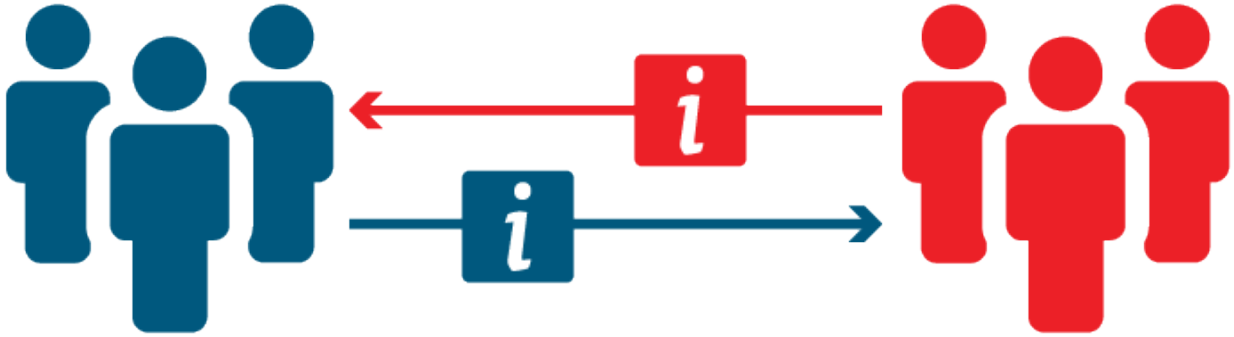
Each planning body informs the other of their work using presentations, reports, webinars, conference calls, and other communication activities.



Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

Information Sharing: In Action!

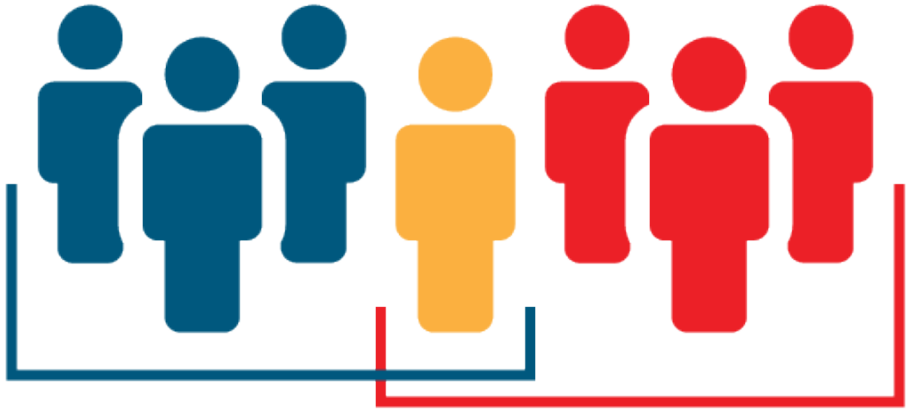
A representative from local HPG attends Part A PC/PB meeting and provides reports on issues impacting HIV prevention services statewide and nationally.



Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

2. Cross-representation

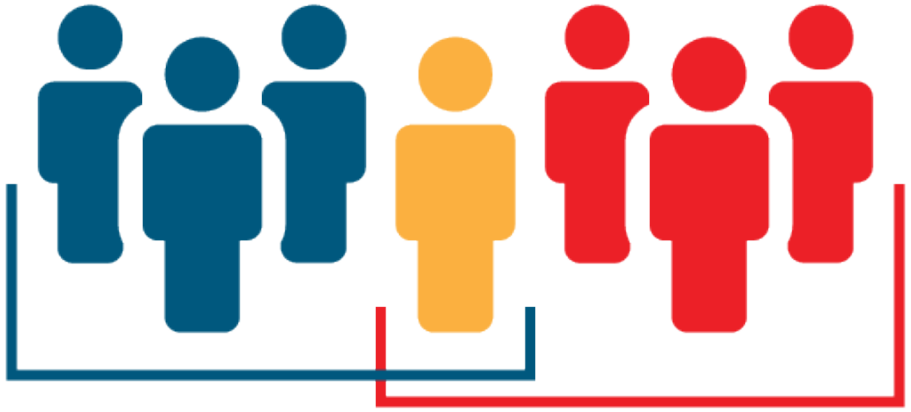
One or more members of each planning body serve as members of the other body.



Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

Cross-representation: In Action!

An HPG representative serves as a member of the RWHAP Part A PC/PB.



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3. Integrated Information Gathering and/or Data Analysis

Care and prevention planning bodies engage in data-based collaboration through joint activities:

- Needs assessment activities
- Evaluations
- Consumer input activities (e.g. town-halls, roundtables)
- Analysis of jurisdictional HIV Care Continuum data
- Service planning and strategy development

Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

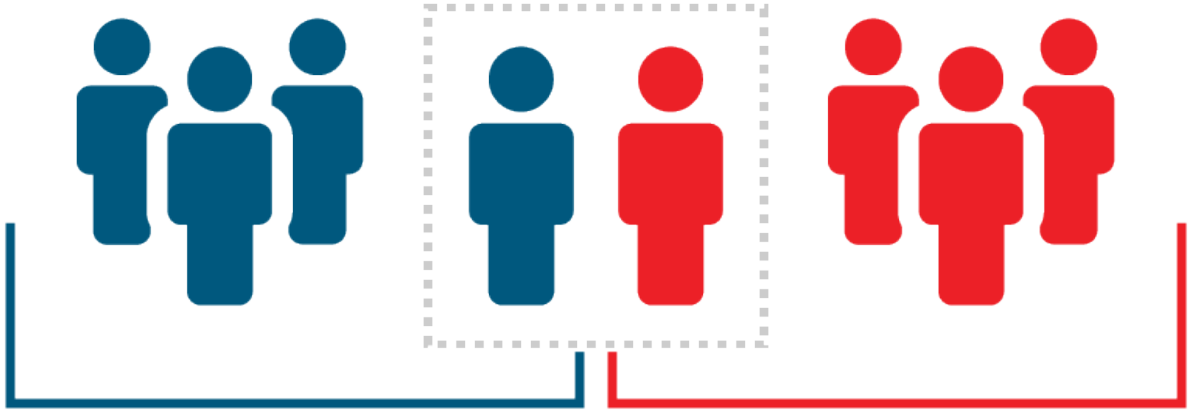
Integrated Information Gathering: In Action!

- A joint workgroup with prevention and care representatives designs and implements needs assessment and develops epidemiological profile for both the state and the Part A jurisdiction
- HPG participates in development of RWHAP Statewide Coordinated Statement of Need
- In 2018, the Ohio RWHAP Part A and Part B programs and the Ohio Department of Health HIV Prevention program began to conduct a multi-year joint statewide needs assessment targeting Ohioans at-risk for HIV infection and individuals living with HIV

Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

4. Integrated Committee of a Larger Planning Body

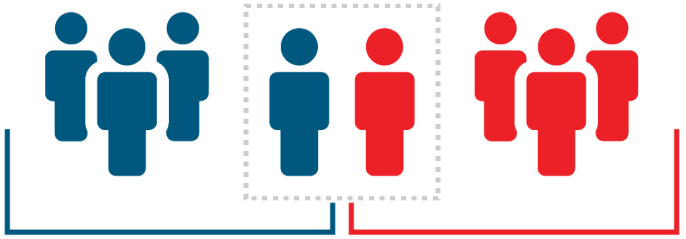
Standing committee on a larger planning body carries out collaborative planning tasks for both prevention and care.



Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

Integrated Committee of a Larger Planning Body: In Action!

- RWHAP Part A PC/PB establishes standing Prevention committee or a joint program committee.
- In Houston, the EIIHA (Early Identification of Individuals with HIV/AIDS) Workgroup includes members of the Ryan White Planning Council and the Houston Prevention Planning Group, who work together on an EIIHA strategy.



Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

5. Unified Prevention-Care Planning Body

Single statewide or Part A regional planning body responsible for carrying out both prevention and care planning.

Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

Unified Prevention-Care Planning Body: In Action!

- Advisory Body housed in State Department of Health responsible for conducting care and prevention planning.
- Combined prevention and care planning bodies in cities that receive RWHAP Part A funds and those that both do and do not receive direct-CDC prevention funds.
- St. Louis, San Diego, Kansas City do not receive direct CDC-prevention funds but have been integrated into the work of RWHAP Part B care planning bodies.

Adapted from EGM Consulting resource 'Integrated HIV Prevention-Care Planning Activities'

Benefits of Integrating Planning Activities

- Provides opportunity to take an initial look at the full spectrum of needs across the entire HIV care continuum without being limited by restrictions associated with funding streams.
  - This is key when thinking strategically about ending the epidemic
- Facilitates engagement with a broader group of stakeholders
- Allows more time for educational activities on topics related to both care and prevention.
- Promotes efficiencies in use of resources, especially for people who serve on both bodies.

Potential Barriers to Successfully Integrating Planning Activities

- Different roles, responsibilities, and requirements between advisory and decision-making planning bodies
- Cultural and procedural differences between planning bodies
- Historic relationships between care/prevention and across RWHAP Parts within local community
  - Requires members to think more broadly and beyond the scope of *only* care or prevention.
  - Must establish trust among all participants and ensure everyone has equal voice at table

Potential Barriers, Continued

- Maintaining manageable membership levels while still meeting Part A PC/PB legislative requirements
- Managing limited meeting time to complete a number of activities and meet all deadlines
- Administrative and financial challenges
- Different terminology, or different definition of certain terms or even service categories

No One-Size Fits All!

- Every jurisdiction is different
- Integrated planning activities should be developed with the unique considerations of local community in mind
- There is no ‘correct’ structure for an integrated planning group
  - Leadership structure
  - Membership
  - Frequency of meetings
  - Types and structure of workgroups/committees

Merging HIV CARE and HIV Prevention Planning Councils in San Francisco

Mark Molnar
Program Director, Planning Council Support
San Francisco HIV Community Planning Council

2004: Precursor to merger

- HIV Work Group convened by HIV Health Services leadership; included service providers and planning council members.
  - Recommendations included merger of HIV CARE and HIV Prevention Planning Councils
- RWHAP Part A-funded Centers of Excellence include funding from HIV Prevention for Prevention with Positives interventions
- “Points of Integration Committee” consisting of members from both planning bodies established
  - Group goals include review of disparities and proposals to reduce disparities

Tipping point

- Emphasis on collaboration and community-based models by various entities
  - National HIV Strategy
  - Joint letter from CDC and HRSA
  - San Francisco Department of Public Health (DPH) and Mayor's Office
- Director of DPH separately addresses HIV Health Services Planning Council (HHSPC) and HIV Prevention Planning Council (HPPC)
  - Stresses importance of looking at HIV services as existing on a continuum that includes both HIV prevention and HIV care.

2013: First attempt at merger

- Merge Task Force convened
- Merger Task Force convened and includes leadership of both councils and nominated members
  - Facilitation of meetings led by consultant experienced in continuum of HIV Prevention
  - Developed 3 possible models of merger
  - Determined policies and procedures and council membership protocols would be determined after merger
- Merger comes to a vote:
  - HPPC votes to pass
  - HHSPC votes to fail

Next steps

- Took a one year hiatus of merger discussions
- Essential Health Benefits Work Group formed to address changes to health care in California
  - Included members of both HHSPC and HPPC
- Council staff interviewed HHSPC council members to learn more about barriers to merger
- HHSPC council members introduced and approved a series of motions regarding the merger
  - Focused on establishing membership protocols and the importance of centralizing consumer voices

2015: Second attempt at merger

- Both prevention and care councils approve formation of a Transition Team composed of nominated council members and Department of Public Health staff.
- Consultant with experience in models of communication and community planning hired to facilitate process.
- Transition Team motions for by-laws change that would allow the HHSPC's Steering Committee and the HPPC's Executive Committee to merge

Joint Leadership Committee

- Joint leadership committee conducted a number of merger-related tasks and activities
  - Made final decision on model of merger
  - Finalized membership and council composition requirements and member approval process
  - Reviewed all by-laws, policies, procedures, and membership requirements from both councils and unified policies
- Continued to conduct regular business as leadership committee for both councils, facilitating greater understanding of each council's work for everyone involved.

Councils merge

- Three joint meetings of HHSPC and HPPC conducted prior to merge.
  - October 2015: joint meeting reviewed policy and procedure motions put forward by Joint Leadership Committee on merged council
  - March 2016: joint meeting reviewed council membership, leadership structure, meeting day/time/frequency, membership application, and proposed name of merged body
  - May 2016: final review of new by-laws, policies, procedures; vote on dissolving HHSPC and HPPC
  - June 2016: vote on forming new HIV Community Planning Council (HCPC)

HIV Community Planning Council structure

- Steering Committee composed of council and committee co-chairs and elected “at-large” members
- Council members must have a home committee, with no separation between prevention and care committees
  - Community Engagement Committee
  - Council Affairs Committee
  - Membership Committee
- Work groups established
  - Ad hoc Needs Assessment Work Group
  - Ad hoc Homeless Work Group,
  - Ad hoc Integrated Plan Work Group
  - PLWH Advocacy Work Group (re-established)
- HCPC meets once a month, 3 hours

2017: Post-merge evaluation

- Consultant hired to evaluate merger and determine any post-merge challenges.
  - Conducted a number of 1-on-1 interviews and several focus groups.
- Primary findings:
  - Resistance to being passive recipients of information during full council meetings
  - Lack of understanding of HIV prevention system of care by former care council members and vice versa
  - Resistance to being viewed as a “rubberstamp” council and desire to be a part of the actual planning process

Response to evaluation findings

- Trainings on HIV prevention and care systems of care implemented during full council meetings
- Greater efforts to establish stronger connections with (including membership on) other community stakeholders engaged in similar work (e.g. Getting to Zero initiative)
- Number of presentations per full council meetings reduced to two.
  - Presentations to be a combination of standard Power Point presentations, guest panels, small group discussions, feedback sessions, dyads, etc.

Response to evaluation findings, cont.

- "Council member panel" established to facilitate better understanding within council of diversity of council member perspectives/expectations, lived experiences, and systemic goals.
- Roadmap Task Force established in collaboration with Department of Public Health
  - Tasked with reviewing integrated efforts between different silos of relevant programs (e.g. HIV prevention, HIV care, Hep C, STI, mental health, substance use, jail services).
  - Introduced motions for HCPC approval regarding systemic integration and change.

Lessons learned

- Primary lessons learned:
  - There must be a commitment to establish new norms
  - Community voices must be centralized
  - The work must be collaborative

Memphis HIV-Care and Prevention Group (H-CAP)

Parrish Oglesby

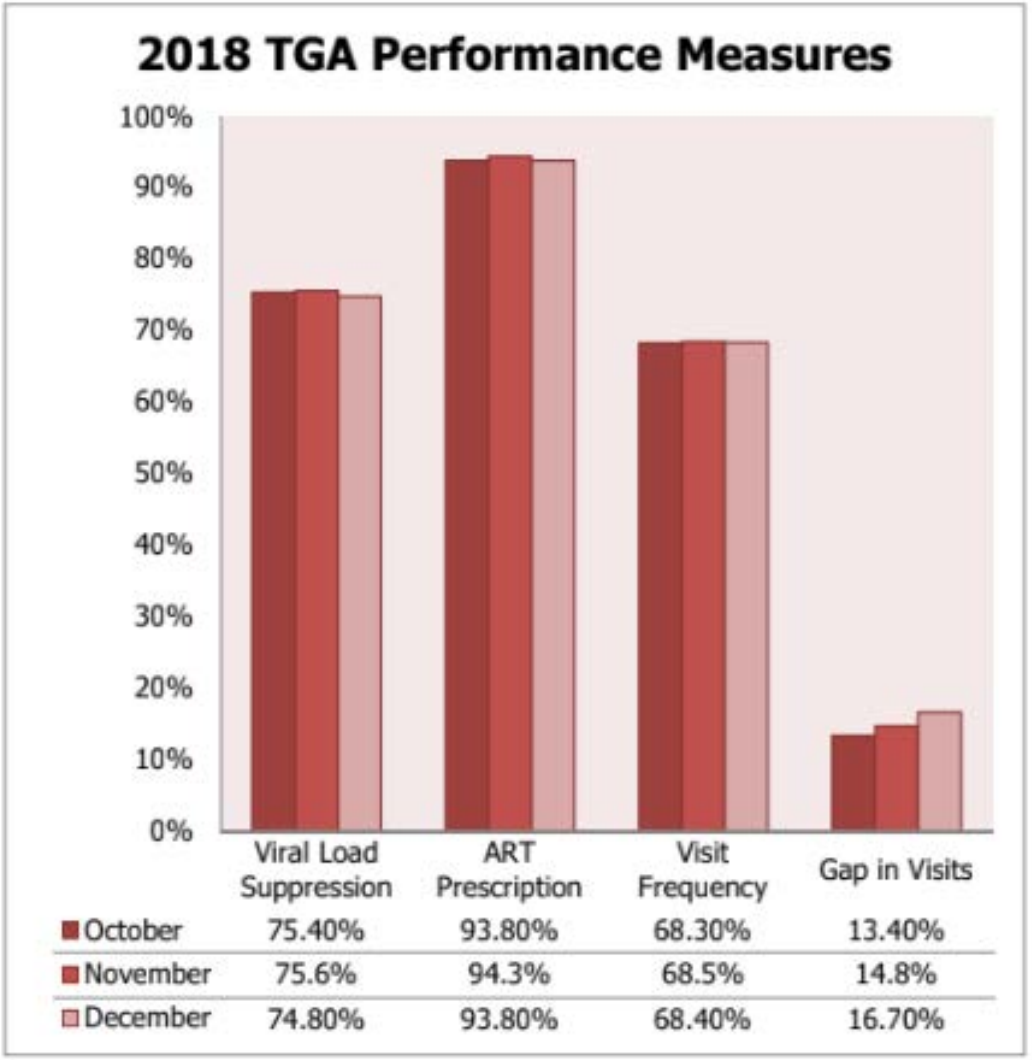
Planning Manager, Memphis HIV Care and Prevention Group

Memphis Transitional Grant Area (TGA)

- Shelby County, TN awarded RWHAP funds under the Part A program in 2007
- TGA consists of 8 counties that cross multiple state lines:
  - Shelby, Tipton, and Fayette counties in Tennessee
  - Crittenden county in Arkansas
  - DeSoto, Marshall, Tate, and Tunica counties in Mississippi
- Planning Council established and began work March 1, 2008

Demographics of Memphis TGA

3,866 clients served by Part A program



Prevention funding in Memphis, TN

- Shelby County was awarded State of Tennessee, Department of Health, HIV/AIDS/STD Section for HIV Prevention funding by the Centers for Disease Control (CDC) in January 2013.
- Services are reserved for individuals living within the boundaries of the Southwest Tennessee Region- Shelby, Tipton, and Fayette counties

Decision to Integrate Planning Activities

- Began exploring integrated planning activities in 2016
  - Propelled by the recognition of the importance of integration and also recognizing it as a trend among other successful TGAs
- Began integration efforts in late 2016
  - Planning Council Support Staff led integration efforts
  - Took 6-7 months to finalize
  - By-laws and policy and procedures took 1.5 years to update

Process of Integrating Planning Activities

- Biggest challenge was gaining trust of care and prevention representatives and assuring no voices would be lost in merger.
  - Prevention had to be convinced they would not be pushed aside
  - Care had to be convinced to be open to adding prevention topics to every meeting

Process of Integrating Planning Activities

- Created ad-hoc meetings with leadership of both prevention and care and “hashed it out”
  - The process was often personal and sometimes emotional
  - Required strong facilitation skills
- Each meeting involved naming out-loud what items the group could agree on and what needed to be moved to ‘parking lot’
- Meetings lasted for ~6 months

Stakeholder Engagement

- Effective integration required engagement of broad group of stakeholders:
  - Influential activists outside of the Part A planning council
  - HCAB members
  - Engaged educators at local universities
  - Local HIV medical providers

HIV Care and Prevention Group (H-CAP)

- H-CAP formally created in Spring 2017
- Comprises 25-36 members
- HRSA and CDC planning body representation requirements
- H-CAP comprises:
  - Two Planning Group co-chairs
  - Secretary
  - Three standing committee chairs
  - Four prevention representatives to the Tennessee Community Planning Group

Training and orientation

- Extensive training and education conducted for all members on both care and prevention issues
- Employed ‘train the trainer’ model for leaders on both prevention and care side
- Held mandatory orientation sessions
  - 8 sessions on Friday nights
  - Required for all members

Membership in action

- Each H-CAP member represents both prevention and care
  - Roles are not siloed
- Formalized transparency around conflict of interest
  - Members ‘wear’ their conflicts on name-badges

Lessons learned & promising practices

- Facilitator of integration should act as referee
  - External or internal facilitation can work
- Recognize the personalities at play and honor the ways personal life experiences impact a person's dedication to the planning process.
- Amount of money prevention and care should remain irrelevant in terms of how much power or influence each 'side' receives.
- Ensure all stakeholders are at the table during each integration discussion.

Questions

Please chat your questions into the Chat Box.

IHAP TAC Webinars

- Access our archived and upcoming webinars www.targetHIV.org/ihap/webinars
- Coming Soon!
  - Incorporating Hepatitis C in Integrated HIV Prevention and Care Planning: Health Department Challenges and Lessons Learned in Aligning Resources, Strategies, and Services to End the Epidemics
    - TBD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Obtain more information, join our mailing list, request TA, or share your experiences or resources.

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