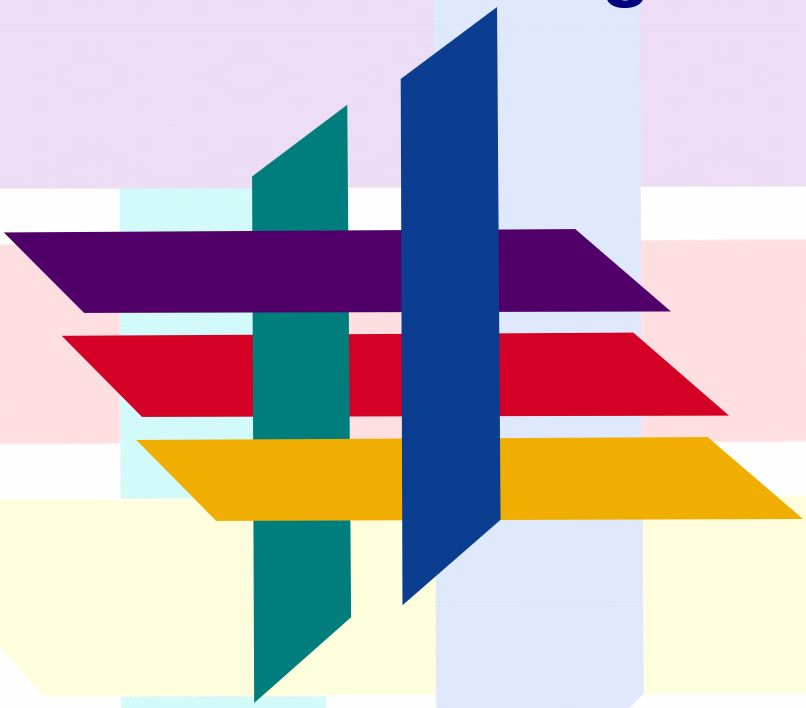
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

NCHHSTP External Consultation on Program Collaboration and Service Integration



Meeting Report Summary

August 21–22, 2007

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Executive Summary

Overview

Program collaboration and service integration (PCSI) is a major strategic priority for the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (hereafter referred to as NCHHSTP or the National Center). PCSI is focused on improving collaboration between programs in order to enhance integrated service delivery at the client level, or point of service delivery. The goal of PCSI is to provide prevention services that are holistic, evidence-based, comprehensive, and high quality to appropriate populations at every interaction with the health care system.

PCSI Operating Definition:

A mechanism of organizing and blending interrelated health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services.

Context

The National Center convened an External Consultation on Program Collaboration and Service Integration in Atlanta, Georgia, on August 21–22, 2007. The purpose of the consultation was to engage key NCHHSTP internal and external stakeholders in developing and refining the National Center's vision and objectives for PCSI and to plan and prioritize PCSI activities over the next five years. Participants were asked to focus on confirming the framing of PCSI, identifying what CDC can do to assist local PCSI efforts, and identifying what CDC can do to improve its own efforts toward PCSI. To achieve general agreement, the National Center set very specific outcomes for the meeting—to obtain the top three NCHHSTP priorities for each of the following:

- Opportunities for PCSI implementation
- Policy improvements needed in support of PCSI
- Performance measures for levels of PCSI
- Workforce development and training needs in support of PCSI

The more than 120 participants of the consultation included a broad range of internal and external stakeholders. In addition to NCHHSTP leadership and staff, attendees included representatives from 40 state and local HIV, TB, STD, and hepatitis programs; other federal agencies; national organizations; and community-based organizations funded by NCHHSTP.

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Meeting Outcomes

To accomplish meeting outcomes, participants worked in small groups to generate priorities and as a large group to discuss issues and reach general agreement on final top priorities.

Top Priority Opportunities

The following emerged as the top three priority opportunities when priorities from the small groups were combined.

1. Integrated Surveillance Efforts

- Achieve leadership consensus for surveillance integration (agreement across geographic areas and programs, agreement on legal issues, partner engagement, and prioritizing integration)
- Increase funding and resources for surveillance
- Build epidemiologic and surveillance capacity at the state and local level
- Develop common definitions of surveillance, harmonize data elements, formats, security and confidentiality standards across NCHHSTP programs

2. Integrated Training Efforts

- Increase workforce development and cross-training on NCHHSTP disease areas and prevention techniques for federal, state, and local public health staff
- Increase opportunities for shared training and education programs within NCHHSTP disease areas
- Develop and promote PCSI training and education to promote shared understanding and vision for state and local public health officials

3. Integrated Funding Efforts

- Develop and promote integrated NCHHSTP program announcements
- Promote and reward collaboration on NCHHSTP program announcements and post-award management at CDC
- Identify mechanisms and incentives for state and federal funding to support integration of NCHHSTP programs
- Allow flexibility of funds to accomplish state and local objectives
- Fund and support evaluation and operational research/evaluation on service delivery integration for NCHHSTP program areas

Executive Summary

Top Policy Improvements

Federal partners divided into two groups to prioritize the proposed policy improvements. The following are the policy improvements selected for the top three priorities:

1. Toward Integrated Surveillance

- NCHHSTP Divisions to develop internal and external work group on surveillance integration
- NCHHSTP Divisions to establish guidelines for integrated surveillance
- NCHHSTP OD to track progress to coincide with development of PCSI white paper
- NCHHSTP OD and Divisions to time guidance and changes to coincide with surveillance cooperative agreement schedules

2. Toward Integrated Training

- NCHHSTP OD and Divisions to provide training on PCSI for all Center project officers and program consultants

3. Toward Integrated Funding

- CDC/NCHHSTP to fund pilots/demonstration projects of new PCSI opportunities
- CDC/NCHHSTP to fund evaluation and operational research on PCSI
- NCHHSTP Divisions to collaborate on program announcements and post-award management
- NCHHSTP and partners to conduct national assessment of level of existing PCSI
- NCHHSTP OD to investigate the use of flexible funding across categorical programs

Performance Measures for Each Level of Integration

Using the typology for integrated HIV, viral hepatitis, STD, and TB preventive services proposed by the National Center, state and local partners working in small groups developed suggested performance indicators for activities for each of three levels of PCSI in four venues (TB, STD, HIV care clinics, and correctional facilities). All groups successfully used the proposed typology to categorize levels of PCSI. Two of the groups recommended that the PCSI typology be expanded to four levels, with level one as “no integration.”

Executive Summary

Workforce Development and Training

Suggestions for collaboration on training included more collaboration with the National Network of STD/HIV Prevention Training Centers (NNPTC) on joint conferences and trainings; inclusion of the Regional TB Training and Medical Consultation Centers (RMTCC) in cross-training efforts; leveraging funds for cross-National Center training; using a national advisory board for high level collaboration; and convening federal partners to brainstorm on training. It was emphasized that workforce development includes both integrated training and training on PCSI. Training CDC project officers and program consultants on PCSI was among the top policy improvements identified during the consultation.

Next Steps for CDC

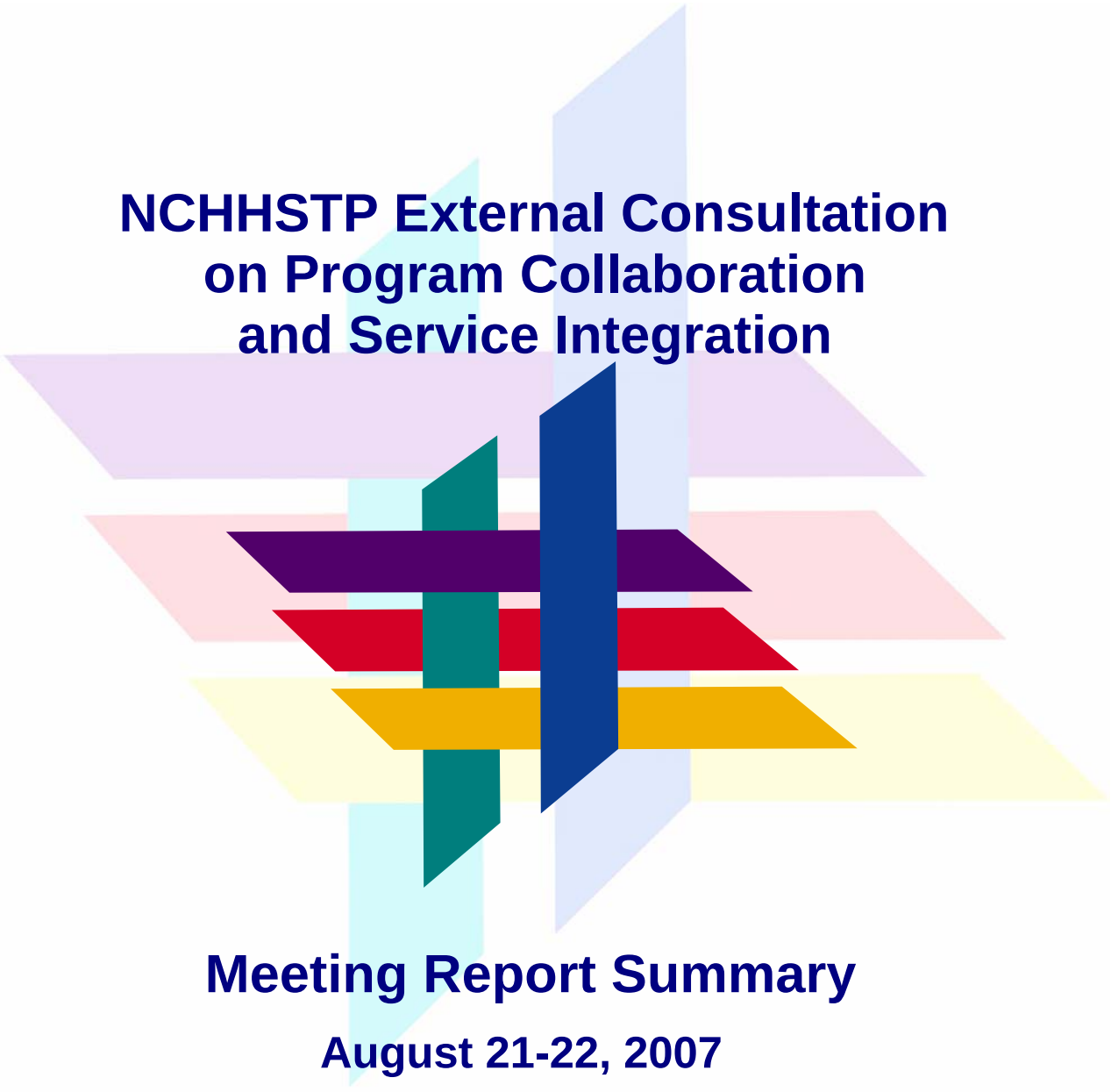
Based on input from consultation participants, the National Center proposes the following next steps for CDC to further PCSI efforts:

- Widen the circle of engagement to involve community prevention services
- Summarize existing evidence and experience in PCSI
- Develop a PCSI implementation action plan with associated partnership activities at the federal, state, and local levels
- Develop a framework for national policy on PCSI
- Explore funding options for "cost neutral" PCSI activities
- Continue coordination on program announcements

Conclusions

The consultation was successful in validating the National Center's framework for PCSI and reaching consensus on priority opportunities and attendant policy improvements in three areas. The consultation was useful in providing input to refine the vision/mission, and typology for PCSI, and to inform development of a policy framework or white paper for PCSI. The consultation demonstrated partners' commitment to PCSI and eagerness to broaden the conversation concerning PCSI to include community partners, especially partners serving vulnerable populations.

NCHHSTP External Consultation on Program Collaboration and Service Integration



Meeting Report Summary

August 21-22, 2007

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Background and Context

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) has set Program Collaboration and Service Integration (PCSI) as a strategic priority. An external consultation on PCSI was convened to engage key stakeholders in advising the National Center on priority actions and activities to facilitate greater collaboration across programs and service delivery integration. Background and planning prior to the consultation focused on identifying barriers to PCSI, developing key questions and a meeting structure designed to address these barriers; identifying opportunities for PCSI; and advising NCHHSTP on top areas for action.

Recognizing that attendance at the external consultation would be limited and wanting to gather wider input, NCHHSTP worked with key stakeholder organizations to obtain additional input on the vision, structure, and strategic plan for implementation of PCSI. These stakeholder organizations were also part of the planning committee for the consultation and included:

- National Alliance of State and Territorial AIDS Directors (NASTAD)
- National Coalition of STD Directors (NCSD)
- National Tuberculosis Controllers Association (NTCA)
- Urban Coalition for HIV/AIDS Prevention Services (UCHAPS)
- National Network of Prevention Training Centers (NNPTC)
- Council of State and Territorial Epidemiologists (CSTE)

Input from over 50 grantees was compiled and circulated to meeting participants prior to the consultation. Key themes from the stakeholder input were also displayed via PowerPoint presentations during the external consultation.

Prior to the external consultation, NCHHSTP also prepared a "green paper" articulating a vision and goal for program collaboration and service integration, and illustrating how NCHHSTP will work with partners at national, state, and local levels to advance this strategic priority. The green paper introduced the concept of PCSI Levels of Integration based on existing CDC guidelines as a strategy to conceptualize, implement, and deliver holistic, evidence-based, and comprehensive services to appropriate populations in clinical settings. During the consultation, participants had an opportunity to apply these PCSI levels to four specific venues.

What is a green paper?

A discussion document intended to stimulate debate and launch a process of consultation on a particular topic. It may be followed by a white paper, the official set of proposals that is used as a vehicle for policy development.

Background and Context

Plenary sessions were designed to introduce concepts and key themes. Facilitated small group sessions were designed to maximize discussion and innovation and to focus on setting priorities.

Consultation participants included a broad range of federal staff and external stakeholders, including CDC and other federal agencies; national organizations; state and local HIV, TB, STD, and hepatitis programs; and community-based organizations. The diversity of the participants reflected CDC's intention to include representatives from large, well-funded programs and smaller programs; from programs integrated both structurally and via service delivery; from urban and rural states; and from higher and lower morbidity states/cities. Invitees also reflected equity across diseases.

Organization of Meeting Report

This meeting report is partially organized according to the meeting agenda (Attachment A); that is, themes from the plenary and small group sessions are summarized and reported in sections corresponding to the agenda. The report is not strictly linear, however, and readers will note that input gathered prior to the consultation from the broader constituency of stakeholders is summarized in sections throughout the report. Some of the dialogue that occurred during question and answer discussions has been edited and placed in sections where it fit best topically. Finally, additional materials, including slide presentations, are included as attachments in the appendix.

NCHHSTP Vision for PCSI

Speakers: **Kevin A. Fenton, MD, PhD, FFPH**, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC
Susan DeLisle, ARNP, MPH, Associate Director for Program Integration, NCHHSTP, CDC

Materials: **Attachment B:** Program Collaboration and Service Integration: Welcome, Vision, and Meeting Objectives (slide set)

Overview

PCSI is a major strategic priority for the National Center. Surveillance and strategic information are important tools necessary to implement, monitor, and evaluate PCSI successfully. Acknowledging the advanced work on PCSI at the local level, *the consultation is "a way for CDC to catch up and move forward."*

Context

NCHHSTP Director Dr. Kevin Fenton presented an overview of the National Center, surveillance data on co-infections, an explanation of PCSI, its priority within the National Center, and detail on the PCSI consultation (Attachment B).

Summary

The mission of NCHHSTP is to eliminate, prevent, and control the National Center's namesake diseases as well as diseases caused by non-HIV retroviruses and non-TB mycobacteria. The National Center was established in 1994, bringing together CDC's HIV, STD, and TB prevention activities. Viral hepatitis prevention activities were added to the mission in 2006. NCHHSTP employs approximately 15% of the CDC workforce (1,500 staff), making it one of the largest national centers within CDC. The National Center has identified three programmatic imperatives: Reducing health disparities; Program collaboration and service integration; and Maximizing global synergies.

Though there is substantial heterogeneity in incidence and geographic distribution of epidemics for HIV/AIDS, viral hepatitis, TB, and selected STDs, often there are common disease determinants. These determinants include similar or overlapping at-risk populations and disease interactions as well as social determinates such as limited access to health care, poor quality health care, stigma, discrimination, homophobia, and poverty. Given these common determinants, NCHHSTP programs "increasingly recognize factors that bind us." Programs, for example, share common purposes and strategies to eliminate health disparities, reduce stigma, prevent disease among the uninfected, interrupt transmission through expeditious diagnosis and treatment and partner elicitation, monitor disease through case surveillance, assure confidentiality, and increase availability of quality, culturally competent services.

NCHHSTP Vision for PCSI

Capitalizing on these common elements was the impetus for NCHHSTP's focus on Program Collaboration and Service Integration as one of the Center's three primary program priorities.

The potential benefits of PCSI are:

- Increased efficiency and reduced redundancy
- Increased flexibility by enabling partners to adapt, implement, and modify integrated services to increase responsiveness to evolving epidemics or changing contexts
- Increased control over operations, using local information from surveillance and key performance indicators

Barriers to implementation of PCSI include:

- Lack of guidelines
- Burdensome administrative requirements
- Lack of integrated data collection tools and surveillance systems
- Insufficient support for cross-training, evaluation, and dissemination of best practices
- Uncertainty about available funding
- Programmatic concerns (loss of program identify, focus, and expertise, mixing of prevention models, and loss of control)

Dr. Fenton outlined the overall objectives of the PCSI consultation. They were to:

- Advise the National Center on the development of PCSI activities over the next five years
- Assist in establishing short- and long-term priorities for PCSI
- Identify what CDC can do to assist local PCSI efforts
- Identify what CDC can do to improve its own efforts toward PCSI

Summary Point: Principles of Effective PCSI

Appropriateness. Integration of services must make epidemiologic and programmatic sense, and should be contextually appropriate.

Effectiveness. Prevention resources cannot be wasted on ineffective or unproven interventions.

Flexibility. Organizations need the ability to rapidly change and assemble new prevention services to meet changing epidemiology, population demographics, advances in technology, or policy/political imperatives.

Accountability. Prevention partners need the ability to monitor key aspects of their prevention services and gain insight on how they can optimize operations.

Acceptability. PCSI must lead to improved acceptability to clients, programs, and providers through improved quantity and quality of the integrated services.

The Public Health Significance of Service Integration: Painting the Picture

Speaker: **Stephanie B. Coursey Bailey, MD, MS**, Chief, Office of Public Health Practice, Office of the Director, CDC
Materials: **Attachment C**: Painting the Picture: A Reality Check, A "Glimpse" into Local Public Health Practice (slide set)

Overview

Promising to give participants a "glimpse" of the reality underlying PCSI, Dr. Stephanie Bailey stated that public health can be as "discrete as a shot or as broad as a flu epidemic." In her words, the challenge is to "not view the shot as an end to itself, nor get lost in the world perspective, nor have such confidence in what is working as to miss what is not working."

Context

Addressing myriad reasons to resist change, Dr. Bailey's presentation brought awareness to the "unknown pictures" of suffering and ultimately disease, brought about by violence, incarceration, substance abuse, truancy, and family disintegration. These and other issues provide the client-focused impetus for PCSI.

Summary

Dr. Bailey first described the familiar picture of urgent threats (e.g., the World Trade Center, SARS, and Hurricane Katrina, etc.) and urgent realities (e.g., suicide, smoking, and tuberculosis).

She next portrayed two "unknown pictures," images she suggested the audience was less familiar with. Her first "unknown picture" was a series of vignettes describing the socioeconomic realities (violence, incarceration, substance abuse, truancy, family disintegration, etc.) influencing the lives of several children. These social costs of disparity, she stressed, require "upstream thinking" because later they will have a disease-related impact.

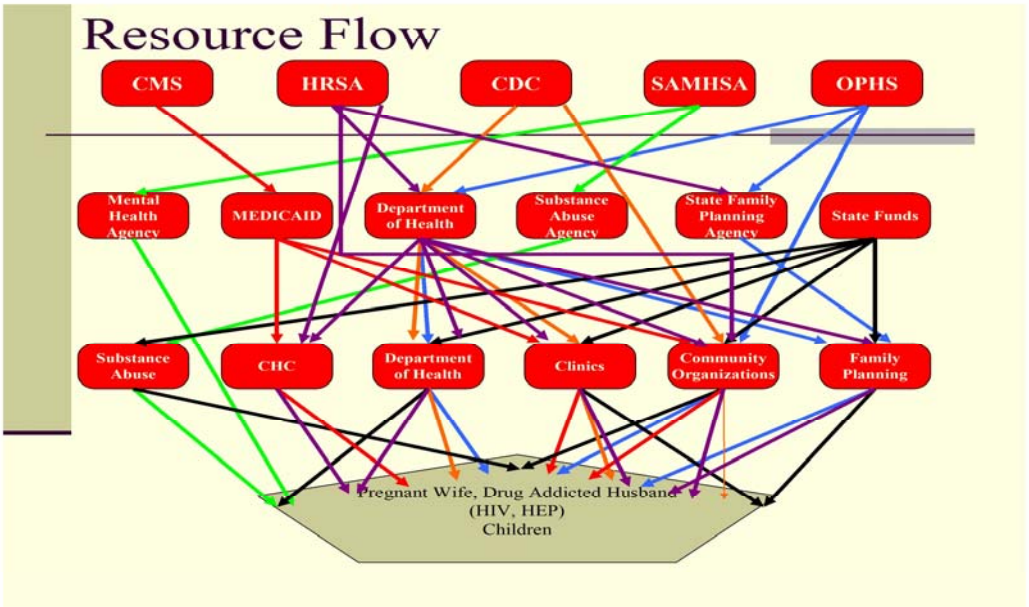
Dr. Bailey's second "unknown picture" illustrated the complex flow of federal, state, and local resources funneled to provide services to individuals at the local level. "Twenty-one different forms and systems just to have integration at the local level!" she stated.

Faced with myriad reasons to resist change, she asked participants to recall her "unknown pictures" representing the client-focused impetus for PCSI.

The Public Health Significance of Service Integration: Painting the Picture

Slide: 50 Reasons Not to Change

Slide: The "Unknown Picture" of Resource Flow from Federal Agency to State Agency to Client



Implementation Plenary: PCSI Experience

Speakers & Materials:	**Brad Hall**, Administrator, Missouri Department of Health and Senior Services **Attachment D:** The History of Program Integration in Missouri: "A Series of (Mostly) Fortunate Events"
	Theresa Henry, Director of Field Services, Virginia Department of Health Division of Disease Prevention **Attachment E:** Program Integration, The Virginia Experience
	Marlene McNeese-Ward, Bureau Chief, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention **Attachment F:** Program Collaboration and Service Integration—The Houston Experience
	Guthrie Birkhead, MD, MPH, Director, AIDS Institute and Center for Community Health, New York State Department of Health (NYSDOH) **Attachment G:** An overview of integration efforts within the State Department of Health

Overview

Themes emerging from the presentations included the importance of leadership at the local, state, and federal levels; the need for clarity on goals/concept of PCSI; the imperative to focus on the client; and the likelihood of "push back".

Context

This session presented experiences with program integration efforts from 4 different health department's perspective. Different models (e.g. structurally non-integrated, partial integration of activities, structurally integrated, matrix management) of program integration were identified and speakers were asked to address 6 areas: (1) what prompted integration; (2) describe any internal barriers to integration; (3) describe any "wins" in integration (at the client level, at HD level); (4) what advice do you have for others embarking on program integration; (5) if starting the process again, what would you do differently; and (6) what would your suggestion be for CDC in providing national direction and leadership on this issue.

Summary

The Missouri Experience

Brad Hall, Missouri Department of Health and Senior Services, presented *The History of Program Integration in Missouri: "A Series of (Mostly) Fortunate Events"* (Attachment D). He described the initial integration of HIV and STD programs, followed by a three-year period of disarray when HIV/AIDS care programs became a

Implementation Plenary: PCSI Experience

The Missouri Experience (continued)

separate division and experienced fiscal crisis, and later successful rebuilding of the care system and renewed community trust.

During the state's most recent reorganization (late 2005), HIV/STD prevention was reunited with surveillance, and hepatitis was added. Further integration with TB is currently stymied but is still being pursued.

> ***Summary Point: Missouri Experience***
>
> Given the reality of integrated service delivery, Mr. Hall called for an integrated data system to show "the big picture of what the client is going through."

Mr. Hall cited barriers to PCSI that include insufficient staff time and motivation, lack of focus, and fear of HIV care encroachment on other programs.

Mr. Hall's advice to CDC and others promoting PCSI:

- Learn from others
- Find and empower your visionary
- Dedicate adequate resources
- Find cheerleaders at the top
- Get buy-in up front
- Keep focus on clients
- Build on small wins & celebrate successes

The Virginia Experience

Theresa Henry, Virginia Department of Health, Division of Disease Prevention, provided an overview of the state's experience with integration. In her presentation, Program Integration, The Virginia Experience (Attachment E), Ms. Henry described the historical trajectory of integration in her state: the coupling of HIV/AIDS with STD, given the similar mode of disease transmission; integration of pharmacy services after realizing that 75% of medications were dispensed for the Division of HIV/STD; addition of TB despite resistance; and integration of hepatitis C based on delivery of services to the same at-risk population.

> ***Summary Point: Virginia Experience***
>
> *Ms. Henry stated that clients in Virginia benefit from more comprehensive services and greater coordination of services.*

Implementation Plenary: PCSI Experience

The Virginia Experience (continued)

Ms. Henry listed programmatic and organizational differences and attitudes as internal barriers to integration. Addressing these barriers in Virginia included the involvement of the human resources department and a concerted effort to promote consistency across programs. Ms. Henry cited lack of support from CDC post-integration as an external barrier.

Resource sharing, enhanced cross-program planning, and a leaner Department of Health are all benefits of program integration in Virginia. Clients benefit from more comprehensive services and greater coordination of services.

Ms. Henry offered these prerequisites for PCSI:

- A leader who strongly believes in integration
- A clear definition of program integration
- Regular cross-program communication

Her recommendations to CDC were fourfold:

- Support integrated programs
- Enhance cross-Division communication within CDC
- Train public health advisors on multiple programs and allow them to work across programs
- Allow for flexible funding

The Houston Experience

Marlene McNeese-Ward, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention, began her presentation, Program Collaboration and Service Integration—The Houston Experience (Attachment F), with a chronology of integrated services in Houston. Declining resources; fragmented, duplicative services; and risk for co-infections among clients engaging in unprotected sex were impetuses for integration.

Ms. McNeese-Ward described the five functional units of the Bureau of HIV/STD and Viral Hepatitis Prevention. Citing the need to establish a bureau able to meet the needs of clients and community partners, she acknowledged that Houston learned and "took a lot from the Philadelphia program."

Ms. McNeese-Ward highlighted PCSI successes. Examples included disease intervention specialists (DIS) housed within high-volume/high-morbidity community and provider sites, a web-based self interview piloted by a CBO, and an expanded syringe access program.

Implementation Plenary: PCSI Experience

The Houston Experience (continued)

Barriers to integration in Houston included staff apprehension concerning new training, lack of staff coordination, funding stream restrictions, and incompatible data systems.

> ***Summary Point: Houston Experience***
>
> Houston's Bureau of HIV/STD and Viral Hepatitis is structured by function rather than disease, allowing for greater PCSI. For example, there is a unit dedicated to public health follow up, which houses DIS and other partner services.

Advice to programs:

- Have a change management plan in place prior to implementation—prepare for contingencies
- Research similar program models
- Consult with key stakeholders—staff, CBOs, legal, Human Resources, etc.
- Memorandums of Understanding (MOUs) can serve to strengthen collaborative relationships
- Strive for transparency in developing new processes
- Collaboration is okay if integration does not occur

Advice to CDC:

- CDC must send the same clear message from all Divisions within NCHHSTP
- Messages must clarify the goal of PCSI-seamless client-level services
- Continued cross-discipline program announcements
- Integration or consistency in program guidance and terminology
- Disseminate best practice models
- CDC must lead by example

The New York State Experience

Dr. Guthrie (Gus) Birkhead, AIDS Institute, New York State Department of Health (NYSDOH), provided an overview of integration efforts (Attachment G). Though agreeing with many of the previous presenters' recommendations on integration, he noted that NYSDOH had relied less on organizational restructuring and more on workgroups to develop a matrix for integration.

Dr. Birkhead reiterated commonly cited reasons for integration: more effective planning, the multi-factorial nature of disease causation and risk, and more efficient use of finite resources.

Implementation Plenary: PCSI Experience

The New York State Experience (continued)

Dr. Birkhead described the complex organizational structure of the NYSDOH, which includes 5,000 employees and four regional offices. Other state agencies and the public health system are important partners for integration. Cross-functional teams have coalesced into permanent workgroups on integration. Describing the evolution of program integration in New York, Dr. Birkhead noted that federal funding often drives integration.

> ***Summary Point: New York Experience***
>
> New York State Department of Health has relied less on organizational restructuring and more on workgroups to develop a matrix for integration.

Dr. Birkhead offered pros and cons for structural and collaborative or cross- functional approaches to integration, noting that New York State found both approaches necessary for successful integration.

Dr. Birkhead provided New York's Hepatitis Integration Project as an exemplar for PCSI. He listed several impediments to integration, stressing that many could be overcome by better communication.

Recommendations for CDC:

- Recognize and promote best practices
- Coordinate with other federal agencies
- Build integrative goals into cooperative agreements
- Give data standards and provide flexibility for providing equivalent data
- Request adequate and stable resources

Implementation Plenary: PCSI Experience

Highlights of Participant Discussion

Q: I think culture of leadership is a factor for change. How much of leadership history influenced what is happening with the change to integration?

A: (Houston) I affirm that change had to do with attitude of leadership; leadership buy-in is key to integration.

Q: In moving to integrate programs, do you monitor to be certain they are more efficiently delivering services?

A: (Missouri) We have not done a good job of monitoring efficiency of integrated programs. We are more focused on client satisfaction.

A: (New York State) We struggle measuring things like vaccinations within an STD clinic, for example, in New York State.

A: (Virginia) During site visits, the coordinator/manager asks local staff about the impact of integrated services. In most cases, we found that additional services did not have an adverse impact.

Q: Has anyone asked the client if integration (i.e., having one staff ask everything) is the optimal way to deliver services?

A: (Houston) We do patient surveys but do not have an answer to that.

A: (Missouri) I have heard that folks like one-on-one interaction, which builds up trust. We are finding that the case manager collects more information than the DIS.

A: (New York State) Do not assume that we are looking for one person to do it all; it is the system that is covering all.

Q: In your state, what was the best single decision around integration and why?

A: (Houston) Our best decision was to co-locate the DIS within the community setting in order to be as responsive as possible to clients.

A: (Missouri) The fact that HIV prevention was integrated with STD up front. As the HIV program evolved, we avoided many issues because the program was based on the existing scenario within STD.

A: (New York State) Integration was more evolution than revolution. The principle of top-down expectations and cross- functional work groups facilitated integration.

Q: Did any of you have to address state or local regulatory laws before integrating?

A: The four presenters all replied no.

Implementation Plenary: PCSI Experience

Highlights of Participant Discussion (continued)

Q: In your cooperative agreements, have any of you built in required indicators or outcomes that address program integration? Secondly, are you doing that as part of your job descriptions?

A: (New York) We are starting to do that and need to do more.

A: (Virginia) We do have some core indicators. A number of them are listed in our pre-consultation document, and it was not an original part of our job description.

Q: Prior to implementing an integrated approach in your respective states, did you convene your evaluators to consider data collection variables? Did you disseminate and train workers on a common tool for data collection?

A: (New York State) Our approach has been to match rather than to integrate data.

A: (Houston) We have a standards of care workgroup and convened a number of workgroups in order to have stakeholders' support, but it was not prior to integration.

A: (Virginia) We did not bring evaluators together before integration.

Q: When considering program integration, did you look at areas as appropriate to integrate versus areas not appropriate to integrate?

A: (New York) The main example for us was hepatitis. After putting together a workgroup, barriers became pretty evident. You do not have to systematically look for a barrier—it just pops up. Our changes have been evolutionary.

A: (Missouri) We systematically looked at integrating HIV. We have not really gone down the road with TB yet.

Q: Fitting TB into integration seems to be difficult. What barriers did you encounter fitting TB into your system?

A: (Virginia) Our barriers included the fact that some TB staff were not engaged in the process initially and CDC's reaction after we merged programs.

A: (Houston) We had a more positive experience. From an epidemiological standpoint, integration made a lot of sense. We were targeting the same at-risk population in the same geographical area. We have just begun collaborating with TB partners.

A: (Missouri) Ours was more of a personality issue. The TB person felt that we were taking things away (e.g., last piece of federal funding). The person's mindset (territorial, not open to change) was a challenge.

A: (New York State) Integration of STD/HIV programs has been institutionalized for 20 years, so lots of things were already in place. An MDR TB outbreak among refugees sparked integration efforts with TB

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Plenary: NCHHSTP Green Paper on PCSI

Speakers: **Kevin A. Fenton, MD, PhD, FFPH,** Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC
Beth Meyerson, MDiv, PhD, Facilitator

Materials: **Attachment H:** Program Collaboration and Service Integration: An NCHHSTP Green Paper Presentation (slide set)
Attachment I: NCHHSTP Green Paper Document

Overview

In his presentation, Program Collaboration and Service Integration: An NCHHSTP Green Paper (Attachment H), Dr. Fenton provided insight on three questions for PCSI:

1. Where are we now?
2. What do we want to achieve?
3. How do we get there?

Context

Dr. Fenton described the green paper (Attachment I) as a "discussion document intended to stimulate debate and launch a process of consultation." The paper describes how the National Center will work with partners to advance program collaboration and service integration.

Summary

The NCHHSTP green paper was distributed to participants prior to the meeting. Emphasizing that the paper was the "beginning of conversation," Dr. Fenton asked attendees to provide feedback on the green paper.

Summary Point: PCSI Drivers, Opportunities, and Motivators

- Overlapping disease determinants and program responses
- The move to a holistic model of disease prevention
- Urgency to reduce health disparities
- Desire to improve delivery of services
- Advances in diagnostic technology and treatment
- Call for more efficient use of federal funds

Plenary: NCHHSTP Green Paper on PCSI

1. Where are we now?

- Limited integration of services
- Marked variation across the United States
- Numerous models of best and promising practices
- Numerous barriers to PCSI
- Programs with concerns about implementation
- Unclear support and incentives for PCSI
- Lack of national leadership on PCSI

2. What do we want to achieve?

Goal: Provide prevention services that are holistic, science-based, comprehensive, and high quality to appropriate populations at every interaction with the health care system.

Vision: Remove barriers to and facilitate adoption of service delivery integration at the client level by aligning NCHHSTP activities, systems, and policies with this goal.

Proposed Typology for Integrated HIV, Hepatitis, STD, and TB Preventive Services

- Level 1 (Limited PCSI): HIV testing and some integration of health information
- Level 2 (Expanded PCSI): Service integration across programs funded by CDC based on risk assessment.
- Level 3 (Comprehensive PCSI): Service integration across systems of care (CDC or other) based on risk assessment.

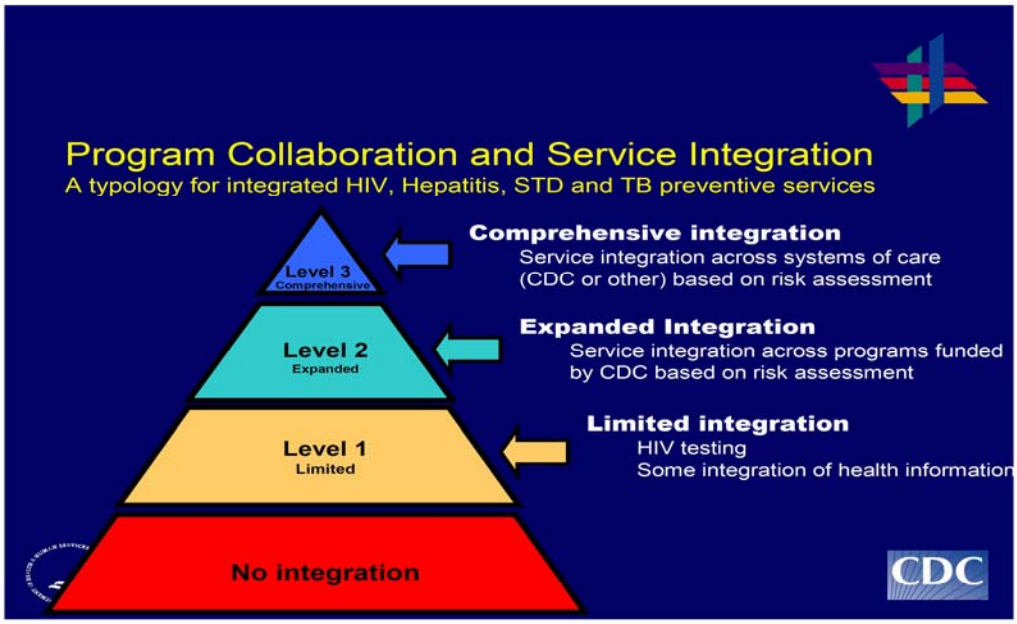
Summary Point: Levels of PCSI

Dr. Fenton reviewed preventive services for each level of PCSI. At Level 1, HIV testing is recommended regardless of behavior risk— a fundamental service and a base for integrated services. Dr. Fenton suggested that reproductive health services might be added at Level 2.

Plenary: NCHHSTP Green Paper on PCSI

3. How do we get there?

Internal and external stakeholders' agreement on a PCSI typology is crucial for success. Dr. Fenton presented the typology for PCSI proposed in the green paper—a pyramid with three levels of progressively greater integration (limited, expanded, comprehensive) arising from a base of no integration. Noting that "no previous typology exists for HIV/Hepatitis/STD/TB," Dr. Fenton stressed that the proposed typology was not "hard or fast" and that CDC was interested in participant feedback.



Champions of PCSI are needed at all levels. Partners can articulate a shared vision for PCSI if they are willing to look beyond cultural differences. Dr. Fenton said that feedback from participants would be used to champion the proposed vision for PCSI. Dr. Fenton encouraged attendees to continue to identify opportunities for PCSI.

Summary Point: Ongoing work on PCSI

- Articulate a shared vision
- Agree on PCSI typology
- Assess current distribution of integrated services
- Clarify roles, responsibilities, and governance
- Establish training, guidelines, and policies for transformation
- Monitor and evaluate progress in implementation
- Measure and reward performance

Plenary: NCHHSTP Green Paper on PCSI

3. How do we get there? (continued)

Dr. Fenton reviewed the roles and responsibilities of both CDC and partners. Collaboration is needed to establish a baseline, and a measurement system (process measures and performance indicators) to track progress on PCSI is vital.

Along with monitoring and evaluation, Dr. Fenton noted the need for a research agenda to help instill increased confidence in PCSI as a public heath intervention. He also emphasized that there should be an expectation of cross-agency collaboration for quick, early, positive reinforcement of successful PCSI efforts.

Participant Comments

Many participants commended NCHHSTP on the green paper and noted it was a productive beginning. Some concerns were raised, including:

- TB regional and medical consultation training centers are not explicitly mentioned, while HIV and STD training centers are.
- The paper is organized by levels of PCSI rather than by venue of services. Level of PCSI means different things for different venues.
- The paper needs more clarity/guidance on prevention services and HIV/AIDS care.
- The use of the term “risk assessment” needs to be clarified, and perhaps CDC should consider developing a common risk assessment tool.

Breakout Report Back: PCSI Vision and Implementation

Overview

Participants divided into five smaller groups, one group consisted of NCHHSTP employees, and the remaining four groups included an equitable representation from all programs and a distribution of other federal and non-federal partners. Groups were asked to identify opportunities for PCSI, prioritize five, and then identify five policy improvements related to the five opportunities. Ultimately, each group prioritized similar opportunities and policy improvements, thus the outcomes were merged into a single set.

Summary

Breakout Group Priorities for PCSI

The breakout groups brainstormed opportunities and policy improvements for approximately an hour and then used a voting process to identify the top five priority opportunities and policy improvements.

Group I: Red Group Priorities

1. Integrated surveillance reports
2. Mechanisms for incentives for state funding (and possibly federal funding) to support PCSI
3. Integrated program announcements
4. Cross-trained NCHHSTP project officers
5. Move away from disease-focused approaches towards a more comprehensive, client-centered prevention approaches

The Red Group's first opportunity, integrated surveillance reports, included several policy improvements focused on guidelines for an integrated electronic surveillance reporting system and ways funding could be used to leverage PCSI.

Group II: Yellow Group Priorities

1. Clear and common goals for PCSI at the client level with public health outcomes (link services and programs to these); integration of disease-specific outcome measures—broader, more client-based
2. Model integration (at least linkage) in CDC programs (e.g., data collection systems, surveillance, case management); registry matching or data integration; addressing confidentiality barriers (sharing patient data between programs and GIS)
3. Funding flexibility; more outcome-based funding to provide the best services available to clients; include program guidance, reporting, and evaluation components

Breakout Report Back: PCSI Vision and Implementation

Group II: Yellow Group Priorities (continued)

4. Integration of STD, HIV, TB, and viral hepatitis program training and education (e.g., conferences)
5. Integration of STD, HIV, TB, and viral hepatitis prevention program planning

Policy improvements listed by the Yellow Group under the first three opportunities included data sharing requirements, systems compatibility, and common risk assessments across programs.

Group III: Green Group Priorities

1. Sharing data
2. Providing comprehensive HIV/STD/TB/hepatitis services
3. Comprehensive risk assessment
4. Addressing health disparities
5. Shared training and education

Policy improvements for each included amending laws, flexible funding, and comprehensive integrated guidelines.

Group IV: Red/Green Group Priorities

1. Well-defined and funded collaborative surveillance systems
2. Workforce development for PCSI
3. Comprehensive and integrated risk assessment tools
4. HIV/STD/Hepatitis/TB targeted for substance abuse and homeless shelters
5. HIV/STD/TB/immunization in correctional settings (jails, prisons, and halfway houses)

This group did not have sufficient time to discuss policy improvements.

Group V: Blue Group Priorities

1. NCHHSTP Division collaboration on program announcement and post-award management
2. Science-based strategy of when to integrate NCHHSTP Programs
3. Cross training on programs—staff internally at CDC and provision of PCSI training and tools for external audiences

Breakout Report Back: PCSI Vision and Implementation

Group V: Blue Group Priorities (continued)

4. Funding for pilots of service integration opportunities—evaluation and incentives for existing programs
5. Information systems that are compatible and accessible at the clinic level

The Blue Group opportunities can be considered policy improvements.

Common Outcomes: Priority Opportunities and Policy Improvements

The breakout groups prioritized similar opportunities and policy improvements. Outcomes that were common across all groups were identified and presented to obtain agreement from the group. General agreement was reached on the three key priority opportunities: (1) integrated surveillance, (2) integrated training, and (3) integrated funding. Accompanying policy improvements are:

1. Integrated Surveillance

Opportunities

- Integrated surveillance reports
- Data sharing
- Redefine surveillance priorities across programs
- Guidelines for an integrated surveillance electronic reporting system with integrated data to include common demographics, variables, and definitions

Policy Improvements

- Establish guidelines for an integrated, electronic surveillance reporting system with integrated data, common demographics, variables, and definitions
- Require data sharing and system compatibility
- Redefine surveillance priorities across programs to promote integration
- Address confidentiality issues—create gold standard
- Surveillance systems should work with and across programs

2. Integrated Training

Opportunities

- Workforce development/cross-training on programs
- Shared training and education/integration of program training and education

Policy Improvements

- Flexible funding for training
- Comprehensive integrated guidelines
- Program announcements that include common language and objectives to address Center diseases
- Require training centers to have integrated training curricula

Breakout Report Back: PCSI Vision and Implementation

Common Outcomes: Priority Opportunities & Policy Improvements (cont.)

3. Integrated Funding

Opportunities

- Integrated program announcements/collaboration on program announcements
- Post-award management of integrated program announcements
- Mechanisms for incentives for state and federal funding to support PCSI
- Flexible funding and funding for pilots of PCSI opportunities (including evaluation)

Policy Improvements

- Fund pilots of service integration opportunities—evaluation and incentives for existing programs
- Collaboration on program announcement and post-award management
- Leverage PCSI through grant announcements
- Provide incentives for "in-kind" funds and/or require matching funds
- Reprioritization of funds at CDC
- Reporting and evaluation components

Broader Stakeholder Input

The consultation was limited as to the number of stakeholders; therefore, broader input was acquired from members of national organizations representing CDC-funded programs prior to the consultation.

Minimum level of services

- Access to all HIV, TB, STD, and viral hepatitis services according to practice standards
- All testing and vaccines available, one-stop shopping
- Comprehensive client-centered model with testing, vaccines, broad health education (e.g. obesity, cancer, heart health), and behavior change (e.g. sexual behaviors, smoking)

Goals: Immediate, short, long

- Feds set example and demonstrate integration
- Fund integration specific activities, planning grants, liaison positions, and demonstration projects
- Assess capacity and systems state by state
- Train staff and allow staff to work across programs
- Develop and disseminate program models, guidance, provider education, and mass media campaigns
- Develop process and outcome indicators

Remove Funding Restrictions

- Integrate funding and staff at CDC
- Allow funding for syringe exchange programs
- Health dept to work collaboratively on proposals
- Program reports based on shared objectives
- Ensure care and treatment are integrated with prevention plans

Surveillance Extended Breakout Report

Speakers: **John Ward, MD**, Director, NCHHSTP Division of Viral Hepatitis
Mark Stenger, BS, MA, Epidemiologist, Washington State Department of Health

Overview

Integrated surveillance systems are critical to characterizing the overlapping epidemics, as well as better understanding the disease burden of populations at risk for any disease. An extended small group session comprised of surveillance experts identified and prioritized key opportunities for integrated surveillance within NCHHSTP disease areas. The results of this session were presented to the full group for consideration.

Summary

Dr. John Ward, Director, Division of Viral Hepatitis, presented an overview of the activities of the National Center's workgroup on surveillance. All NCHHSTP divisions are represented in the workgroup. The group's first endeavor is development of a combined surveillance profile for publication by March 2008. In subsequent profiles, the group plans to focus on specific populations, beginning with African-American men. The workgroup, recognizing the value of surveillance for a variety of activities, is striving for both "inside and outside" dialogue. The workgroup hosted a surveillance pre-consultation meeting on Monday, August 20, to discuss integrated surveillance efforts.

Mark Stenger, Washington State Health Department, reported on the outcomes of the August 20 breakout. Mr. Stenger stated that the group identified some of the key issues and challenges of surveillance integration and began to conceptualize surveillance integration using a framework similar to the levels of PCSI. In general terms, the group covered the importance of good data to better target programs, the need to achieve leadership consensus for integration, funding (overall inadequate funding and reprioritization of existing funding), and capacity needs (expertise and infrastructure) for surveillance.

Breakout Outcomes: Key Opportunities for Integrated Surveillance

- Achieving leadership consensus for integration: There is currently little agreement across geographic areas and programs on definitions of integration, legal issues, partner engagement, etc., let alone agreement to prioritize integration, including resourcing.
- Funding issues: There are disparate funding levels, no categorical funding for surveillance in some programs, and inadequate funding overall.
- Epidemiologic and Surveillance capacity: There is a great need for epidemiologic and surveillance capacity building for new and existing staff.
- Real Differences: There are different definitions and uses of surveillance across programs. There is no consensus around data elements or formats, security, and confidentiality standards and handling of multi-national or immigration status.

Surveillance Extended Breakout Report

Questions, Answers, and Comments

Q: Was there any discussion about engaging community clients and leadership around integration efforts, especially given drivers for integration?
A: There was recognition that these communities need to be part of the discussion; however, there was insufficient time to tease out the issue.

Q: Are you talking at the federal level to each state?
A: Since our epidemics vary by region, we must provide capacity at the state and local level to understand existing and emerging co-morbidities. Infrastructure for data collection is also a priority.

Q: Are you planning for some kind of patch so surveillance systems can talk to each other?
A: We did not talk nuts and bolts; we need to conceptualize issues first. Clearly, there are a lot of technical issues to discuss.

Q: What is the process to ensure PCSI and surveillance timeframes match/overlap?
A: The goal is to have a blueprint for surveillance ready at the same time as the white paper.

Broader Stakeholder Input
The consultation was limited as to the number of stakeholders; therefore, broader input was acquired from members of national organizations representing CDC-funded programs.

Surveillance barriers/facilitators that might support or hinder PCSI

- Policies—categorical funding, HIPPA, confidentiality (HIV), reporting forms
- Systems Incompatibility—"it's a mess"
- Infrastructure problems—personnel, funding, and technology
- Big money investment, duplication, yet no cross-communication
- Little political will to reduce duplication
- Lack of epidemiologic infrastructure— Viral Hepatitis and TB
- IT infrastructure is declining (or non- existent); many systems still DOS or paper-based
- HIV willingness to share data with TB/STD
- Declining (or need for) funding

Priority recommendations for surveillance/information collection to support PCSI

- Standardize data elements
- Reduce redundancy
- Improve systems compatibility
- Demonstration projects for integrated electronic surveillance and data management
- Mandate data sharing/matching
- Focus on co-morbidities
- Improve state and federal communication across programs
- Funding for hepatitis C surveillance
- Funding, support, and training
- Electronic lab reporting

Performance Indicator Report Back

Overview

While the external participants worked to develop performance indicators for four health care settings, the NCHHSTP staff worked to determine if the proposed policy improvements identified for the three priority areas (surveillance, training, and funding) were possible to accomplish within the next three years. For improvements deemed possible, the federal staff groups would establish a timeframe and identify what was needed from state and local partners.

Context

The four participant breakout groups were each assigned a clinical venue (TB, STD, HIV clinic, or corrections) to focus their discussions on indicators. Groups were asked to identify three activities that could occur at Levels I, II, and III within their assigned venue and to develop performance indicators for each activity at each level.

Although consideration was given to a participant request to consider indicators for non-clinical settings, the consensus of the CDC leadership was to focus on clinical settings. Dr. Fenton reminded the audience that "this is a beginning conversation" and that subsequent external discussion would include community partners.

Summary

Group 1/TB Clinic Indicators

Group 1 recommended that "non-integration" be considered the first level of integration and be called collaboration. The group suggested that the integration pyramid should be inverted since integration must be driven from the top.

The group reported struggling to identify indicators for a venue that varies greatly by geographic location. Setting activities/indicators for optimal conditions while being aware of real world exigencies were the two most challenging aspects of the task.

Level I

Activities and Indicators

1. All TB programs should implement opt-out, onsite HIV testing to be consistent with 2006 CDC HIV testing guidelines
   - Number of TB programs who have implemented HIV opt-out testing
   - % of clients tested for HIV
2. Referrals for HIV-positive clients
   - % of HIV-positives referred for medical care
   - % who receive followup medical care

Performance Indicator Report Back

Group 1/TB Clinic Indicators (continued)

3. Referrals for a variety of patient services (drug treatment, HIV/STD services, specialty care, etc.)
   - Number of patients referred for services other than medical care
   - % who attend followup care

Level II

Activities and Indicators

1. Assessments performed for HIV/Hepatitis/STD
   - # of clients assessed for HIV/Hepatitis/STD
2. Testing for hepatitis in order to provide vaccinations
   - # tested for hepatitis
   - # vaccinated
   - # completing hepatitis vaccination series
3. Referral for drug/alcohol/mental health services
   - Number of referrals

Level III

Activities and Indicators

1. Partner notification services for all diseases (cross-trained DIS)
   - # of cases interviewed for partner notification
   - # of DIS that are cross-trained
2. Testing for STD
   - # of new STD cases identified
   - # of patients receiving appropriate STD treatment
3. Initiate case management for services and treatment needs (one-stop shopping)
   - # of patients receiving case management services

Questions and Comments

Q: (Dr. Fenton) I commend the TB group for thinking outside the box in including STDs. Did you consider kinds of STD?
A: We decided on all STD.

Group 2/ STD Clinic Indicators

Group 2 would also like to see four levels of integration, with Level I indicating "no integration."

Level I

Activities and Indicators

1. Universal HIV testing
   - % of clients receiving HIV testing

Performance Indicator Report Back

Group 2/ STD Clinic Indicators (continued)

2. Pregnancy testing
   - % receiving pregnancy testing
   - % receiving followup medical care
3. Routine risk assessment
   - % receiving routine risk assessment

Level II

Activities and Indicators

1. TB and Hepatitis C testing and referral
   - % of clients receiving TB and hepatitis C testing and referral
2. Hepatitis A/B vaccines
   - % receiving hepatitis A/B vaccine
3. Reproductive health services (Pap tests, emergency contraception, hormonal contraception) provision and referral
   - % receiving reproductive health services

Level III

Activities and Indicators

1. Comprehensive risk assessment, screening, and referral (including substance abuse, mental health, etc.)
   - % of clients receiving comprehensive risk assessments and referral
2. Tailored risk-reduction interventions and counseling
   - % receiving tailored risk-reduction interventions and counseling
3. Needle Exchange
   - % receiving needle exchange services

Questions and Comments

Q: Please explain the difference between routine and comprehensive risk assessment.
A: Routine risk assessment is disease specific (e.g., HIV, TB), while comprehensive risk assessment is broader (e.g., mental health, housing).

Q: Did you consider hepatitis B screening?
A: It would be worth considering if the venue had the capacity.

Comment: When deciding to include all types of testing in Level III, we need to realistically consider clinic capacity (e.g., full waiting rooms with clients unwilling to wait).

Suggested Additions: testing and vaccine for partners, other partner services, and prevention education/condoms to Level I

Performance Indicator Report Back

Group 3/HIV Care Clinic Indicators

Group 3 assumed that clinics adhere to USPHS clinical standards of care (SOC) at all levels of integration.

Level I

Activities and Indicators

1. Risk assessment (focusing on STD, TB, & Hepatitis)
   - % of clients with an initial risk assessment completed
   - % of clients receiving recurring risk assessment in a specified time period
2. Provide or refer to comprehensive prevention services (STD, TB, hepatitis, mental health, substance abuse, contraception, and emergency pregnancy care)
   - Number of referrals made by type
   - % of comprehensive services provided
3. Health Education and Client Centered Risk Reduction/Harm Reduction (a minimum of condoms and information pamphlets)
   - Proportion of sites with educational material available

Level II

Activities and Indicators

1. Comprehensive Risk Counseling Services (includes broad array of support services not just prevention)
   - Comprehensive Risk Counseling Services
   - % of completed sessions
2. Partner Counseling and Referral Services
   - Partners identified/notified of exposure
   - % tested, % treated, % of partners receiving test results
3. Post Exposure Prophylaxis (PEP)
   - Number of partners informed of availability of PEP

Level III

Activities and Indicators

1. Provide comprehensive reproductive health services onsite
2. Electronic reminder system to conduct comprehensive prevention services
3. Treatment of hepatitis C, opiate addiction, and TB

Group 3 generated a long list of services that are needed at Level 3 in an HIV Care Clinic.

Questions and Comments

Q: Does Level I include syphilis-related services?
A: We assumed SOC as a baseline which includes syphilis.

Performance Indicator Report Back

Group 3/HIV Care Clinic Indicators (continued)

Questions and Comments (continued)

Q: What would the difference be between Level I and zero?
A: Zero would be just SOC and not include activities listed for Level I. We do acknowledge that not all venues are following guidelines.

Q: Where do we get to "clinic provides all this?"
A: A comprehensive clinic is at Level III.

Q: What is the difference between a Level I and Level III clinic?
A: We think of Level I as providing basic level of preventive services and referral, while at Level III all risk assessment identified needs are provided.

Suggested Additions: Case management and offsite services (e.g., direct observation for TB)

Group 4/Corrections Indicators

Note: Referral and tracking (Level II) may not be operationally feasible in correctional settings. Some felt adolescents and juvenile detention centers should be excluded from this discussion; all noted that jails and prisons are very distinct from each other in terms of what can be done within each setting.

Because of the unique characteristics of correctional health care, participants proposed these changes to what services should be minimal at each level:
Level I

- Routine TB screening, with follow-up and treatment if necessary
- Routine STD screening

Level II

- Routine hepatitis C virus (HCV) screening, with follow-up
- Linkage to care for HIV to Level II (post-discharge)

Level III

- Treatment services to Level III (with comprehensive risk assessment)
- Community follow-up—linking to services and discharge planning

Level I

Activities and Indicators

1. Routine STD testing, viral hepatitis, HIV, TB (including HCV and HBV)
   - STD: % tested, % positive, % positives treated
   - TB: % screened, % evaluated appropriately (i.e., according to CDC guidelines), % of positives also screened for HIV
   - HIV: % offered testing, % accepted, % tested, % positive, % informed of result

Performance Indicator Report Back

Group 4/Corrections Indicators (continued)

Level II

Activities and Indicators

1. Hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination
   - % offered vaccine, % receiving doses 1, 2, 3 (emphasis on dose 1)
2. Referral and tracking during incarceration and post-discharge
   - % referred of those identified for specialty care (as per testing and services offered or mandated)
   - Time frame of services offered
3. HBV and HCV screening
   - % offered testing, % accepted, % tested, % positive, % informed of result

Level III

Activities and Indicators

1. Comprehensive risk assessment
   - % receiving, % completing, % referred
2. Comprehensive screening, diagnosis, and treatment
   - As per Level 1 testing algorithms, plus completion of diagnosis and treatment
3. Follow-up in the community, that is, referral for specialist care and tracking that care occurred (discharge planning)
   - % discharged with comprehensive discharge planning

Questions and Comments

Q: For Level I, did you discuss programs approaching corrections separately or jointly?
A: We discussed Florida as an example of a state using a joint approach.

Comment: There are often barriers to getting in prisons; if one program gets a foot in corrections, it opens the door. Getting a foot in the door may be even more important that having resources.

Q: Why is vaccination in Level II and not in Level I? Due to community impact, I would include in Level I.
A: Given more than three choices, we would include as a fourth activity in Level I.

Q: Did you include in risk assessment discussion of illegal behaviors?
A: Yes.

Q: Did you talk about SOC in corrections?
A: We very much did discuss SOC and the difficulty knowing where to start given the level of disparities (e.g., Kansas versus Chicago, big versus little).

Suggested Additions: Case management/referral follow-up; include adolescent population; policy improvements report back

Performance Indicator Report Back

Blue Group 1/NCHHSTP Staff

Note: Due to the large number of NCHHSTP participants and based on feedback from the group participants, the NCHHSTP group was divided into two smaller groups. In general, the groups reviewed the policy actions that fell under the three key priority opportunities identified in the first breakout session (see the "Breakout Session I Report Back" section) and identified what policy actions were "doable" or realistic to accomplish within a three-year timeframe. For the improvements that seemed doable, the groups identified what was needed from state and local partners and what steps would be done at the federal level.

Top Priorities

1. Establish guidelines for integrated surveillance

Needed from Partners: Help defining common variables; participation in external work group; help developing governance policy (e.g., levels of responsibility/decision making, deadlines)

2. Fund pilots/demonstration projects of service integration opportunities

Needed from CDC: Consultation on funding design and priorities; definition of standards
Needed from Partners: Evaluation component built into projects to generate an evidence base

3. Fund evaluation

See number 2 above.

4. Collaborate on program announcements and post award management

Needed from Partners: Feedback on integrated FOAs; expectations regarding post-award management

5. Provide training on PCSI for project officers

Needed from CDC: Satisfaction survey from field regarding PCSI efforts

Needed from Partners: Opportunities for project officers to see integrated programs in the field; expectations of project officers

Questions, Answers, and Comments

Q: Why did you decide requiring data sharing and system compatibility is not doable?
A: CDC can recommend and facilitate but cannot require data sharing and system compatibility.

Q: With a new TB reporting form and new data systems, is there some way to get these deadlines to coalesce?
A: We will have to take this into consideration as we develop our timeline.

Performance Indicator Report Back

Blue Group 2/NCHHSTP Staff

Federal Group 2 agreed on three priorities for policy improvements. Due to time constraints, they identified what is needed from CDC and state and other partners for only the first priority.

Top Priorities

1. Conduct a national assessment of the level of existing PCSI

Needed from CDC: OMB clearance; funding contract (RFP); IRB review; PGO coordination; political will; internal resources (staff, management, etc.)

Needed from Partners: Cooperation; collaboration; assistance in defining what is needed; input from national organizations (e.g., NASTAD, NTCA)

2. Establish guidelines for an integrated surveillance/integrated data reporting system

3. Investigate the use of flexible funding across the board

Performance Indicator Session Discussion Highlights

Q: Data are the lifeblood of our efforts. I would like to suggest Bill Gates as a partner to integrate data collection across programs.

A: (Dr. Fenton) Great suggestion. Yesterday, I had the chance to see what the surveillance workgroup is looking at; it is more than infrastructure. The issue seems to be data sharing. We will revisit this issue.

Q: How will we stave off OMB and others?

A: (Dr. Fenton) In view of the recent OMB audit, we are thinking critically about cross-National Center performance measures. The greatest development we have had in the past five years is the number of new program indicators produced by our HIV team.

Q: One thing that is missing from indicators is the number of new cases treated, which would indicate expansion of services. What is the point of integration—to expand testing or provide better treatment?

A: (Dr. Fenton) This issue came up as to the drivers for PCSI. A major driver for PCSI is to increase the effectiveness of our health care, which includes ascertaining new cases and providing clients with more holistic care. We are listening to you for advice on how to satisfy multiple outcomes.

Workforce Development and Training

Speakers: **Jeanne Marrazo, MD**, Associate Professor, University of Washington
Mark Thrun, MD, Director, HIV Prevention, Denver Public Health.
Materials: **Attachment J:** Workforce Development and Training
Attachment K: External Input on Workforce Development & Training

Overview

Dr. Jeanne Marrazo and Dr. Mark Thrun, Steering Committee Co-chairs for the National Network of STD/HIV Prevention Training Centers, co-presented on workforce development and training (Attachment J). Dr. Marrazo showcased the National Network of Prevention Training Centers (NNPTC) as an example of workforce development integration. Dr. Thrun reminded participants that workforce development and training includes two realms: integrated training and training on PCSI.

Summary

Dr. Marrazo stressed that workforce development and training is a collaborative process across the National Center. The National Network of Prevention Training Centers provides clinical training on STD/HIV prevention, behavioral training on prevention interventions (DEBIs), and both clinical and behavioral training related to partner counseling and referral services.

"Ask Screen Intervene" (ASI) is a curriculum developed by NNPTC for medical care providers for persons with HIV. To illustrate "integration that worked," Dr. Marrazo listed the many domains ASI bridged (e.g., STD and HIV, prevention and care, clinician and PCRS).

Dr. Thrun reminded participants that workforce development and training includes two realms: integrated training and training on PCSI. He urged planners to use the logic model to frame training needs. Dr. Thrun cited "big picture" training issues, identified sources for outside input, and listed areas requiring further collaboration. Dr. Thrun pointed to the need for a cultural shift to enhance buy-in around integrated training and to shift the structure of training to less conventional settings. Concluding the presentation, he emphasized, "We have the knowledge; we need to create action."

Participant Comments & Questions

Q: Could all trainings be listed on the CDC website?

A: Great comment. Inform CDC of your internal trainings. The National Center has a huge consultative network and a large number of training entities to take into account moving forward.

Comment: As far as integration is concerned, webinars are a useful tool—900 persons throughout Canada and the United States attended a recent webinar.

Workforce Development and Training

Participant Comments & Questions (continued)

Comment: Discussion seems to be framed without TB; we must build up TB faculty and staff. We do training. Our training centers have developed a comprehensive guidance in order to develop training. I would love seeing increased access to your databases (to link with state web sites). Action could occur on training the future public health workforce. This is an issue—we do not have mentoring and are not meeting capacity before integration.

Comment: There should be a small group external consultation involving RTMCCs, NNPTCs, and subject matter experts from NCHHSTP Divisions to develop and plan for PCSI training needs.

Comment: For four to five years, Georgia has integrated STD and family planning clinics. They essentially have training onsite with clinical mentoring, practical training, and evaluation.

Response: These are great ways to do TA and capacity building.

Comment: I suggest more focus on hepatitis C. There are few resources not developed by pharmaceutical companies.

Dr. Fenton stated that there were new opportunities for collaboration on training and asked for ideas moving forward. Suggestions included more collaboration with the training centers on:

- Joint conferences and trainings
- Leveraging funds for cross-Center training
- Using a national advisory board for high-level collaboration
- Convening federal partners to brainstorm on training

It was pointed out that doing more necessitated additional funding. It was also noted, however, that just by doing an inventory of integrated courses, CDC could immediately pull together pieces already on the table.

Broader Stakeholder Input

The consultation was limited as to the number of stakeholders; therefore, broader input was acquired from members of national organizations representing CDC-funded programs.

Broader external input regarding workforce development and training is presented in Attachment K.

Prioritization and Next Steps

Speakers: **Kevin A. Fenton, MD, PhD, FFPH**, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC
Materials: **Attachment L:** Next Steps (slide set)

Overview

Dr. Fenton shared his viewpoint that the PCSI consultation was an "incredible accomplishment." The richness of the dialogue, he noted, helped in thinking outside the box with respect to cultural differences.

Summary

Dr. Fenton expressed his pleasure in working with Dr. Meyerson and having the opportunity to get to know and conceptualize PCSI with consultation participants. He elaborated on the drivers of program collaboration and service integration: overlapping epidemics, poor access to quality care for the disadvantaged, and increasing heath disparities. He reiterated that the end goal of PCSI was to extend the reach of prevention services.

Program Reflections

Division of Viral Hepatitis

Dr. John Ward, Director, Division of Viral Hepatitis Prevention, cautioned that PCSI must "make sense for all programs so all can benefit." He also stressed that care must be taken to maintain expertise as PCSI efforts expand.

Division of Tuberculosis Elimination

Dr. Kashif Ijaz, Branch Chief, Field Services and Evaluation Branch, Division of TB Elimination, expressed his excitement at seeing the "synergy and community support for PCSI, especially for services at the client level." He urged participants to be mindful of the five principles of PCSI outlined in the green paper and concurred that maintaining expertise is essential.

Division of HIV/AIDS Prevention

Dr. Robert Janssen, Director, Division of HIV/AIDS Prevention, stated that given under-funding of all programs, PCSI must be a deliberate, inclusive process to yield the biggest impact. Dr. Janssen expressed his full support for efforts to remove non-financial barriers and financial barriers, such as moving money to further PCSI. He suggested an assessment of best practices as an alternative to pilot projects.

Prioritization and Next Steps

Program Reflections (continued)

Division of STD Prevention

John Douglas, Director, Division of STD Prevention, commented that he was highly impressed by the passion in the room. Discussion, he noted, produced concrete ideas that can actually help CDC focus. Echoing Dr. Janssen, Dr. Douglas stated that "impact is going to the litmus test for successful PCSI."

Participant Reflections

Dr. Fenton invited attendees, whether inspired, confused, or challenged, to share their thoughts before leaving.

Many underscored the primacy of inclusiveness, stressing that PCSI efforts must include collaboration with community partners and respect for cultures. Community and migrant health centers were cited as important partners to help define population-based needs. Participants also stressed the importance of including policy makers to ensure long-term impact and including Ryan White programs as PCSI moves from prevention to care.

One participant cautioned that it is sometimes reasonable to separate services and that not all health workers will be capable of assuming cross-program tasks.

Another participant suggested that the "attitude of fear" (e.g., HIV is swallowing us; Hepatitis has no voice) may be the toughest impediment to PCSI. He urged partners to keep talking to one another; the results, he promised, will make a difference for many years to come. Echoing this sentiment, a participant reported feeling much assured "seeing more that we share than what is different."

Additional participant recommendations included a focus on mechanisms needed to make referrals happen and considering substance abuse programs as a source of untapped funding for PCSI.

Prioritization and Next Steps

Dr. Fenton thanked participants for feedback on the green paper, including the levels of PCSI. He noted that CDC has heard "loud and clear" the need to include community partners in ongoing discussion on PCSI. He promised that as work on PCSI continues, expanding from this group to additional circles, these entities will be "part and parcel of the discussion."

Prioritization and Next Steps

Prioritization and Next Steps (continued)

Dr. Fenton presented the next steps for CDC to further PCSI (Attachment L).

- Widen the circle of engagement to involve community prevention services.
- Summarize the existing wealth of evidence and experience on PCSI.
- Develop an implementation action plan (spring 2008) and partnership activities at the state and local level.
- Develop a framework for national policy on PCSI (white paper, winter 2007).
- Explore funding options for "cost neutral" PCSI activities.
- Continue coordination on program announcements.
- Identify priority PCSI interventions.
- Develop research agenda for PCSI.

Dr. Fenton invited consultation participants to submit abstracts for the December 2007 HIV Prevention Conference, which will include a new track on PCSI.

Thanking attendees for "a great three days," Dr. Fenton adjourned the consultation.

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NCHHSTP External Consultation on Program Collaboration and Service Integration

Attachments