Integration of HIV/AIDS, STD, TB and Viral Hepatitis
New York State’s Experience

Guthrie S. Birkhead, M.D., M.P.H.
Director, AIDS Institute
Director, Center for Community Health
NYS Department of Health

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Why Integration?

- An effective way to plan programs and services from the perspectives of:
  - Common risk factors;
  - Same people being served;
  - Same providers in the community.
- Recognize multi-factorial nature of disease causation and risk
- Make most efficient use of scarce resources
NYS DOH Org Chart

Commissioner
  Executive
  Deputy Commissioner

Office of Executive and Advisory Council Operations

Division of Legal Affairs

Office of Governmental Affairs

Public Affairs Group

Strategic Consulting and Organization Performance Enhancement

Division of Administration

Health Facilities Management
  • Helen Hayes Hospital
  • Veterans Homes

OPMC

Office of Health Systems Management

Office of Continuing Care

Office of Medicaid Management

Office of Managed Care

Division of Planning, Policy, and Resource Development

Regional Offices
  • Metropolitan Area
  • Western
  • Capital District Field
  • Central Field

Center for Community Health

Office of Minority Health

AIDS Institute

Center for Environmental Health

Wadsworth Center for Laboratories and Research

Office of Science and Public Health
Important Related Offices for Integration

- Department of Health
  - Medicaid
  - Managed Care
  - Science and Public Health
  - Hospital regulation
- Other State Agencies
  - Correction
  - Alcoholism and Substance Abuse Services
  - Mental Health
  - Parole
- Other
  - Public hospital system
Evolution of Program Integration, New York State

- Mid-1980s – AIDS Institute formed
  - AIDS Surveillance/Epi => Epi Division
  - Enhanced Medicaid $$ => AIDS Institute

- Early 1990s – Address heavy impact of IDU on HIV
  - HIV testing/care collocated with substance abuse treatment services => AIDS Institute/OASAS

- Mid-1990s – Provide partner notification
  - HIV partner notification program => STD program

- Late 1990s / Early 2000s – Hepatitis Work Group
  - Hep surveillance => Epi division
  - Hep C coordinator moved Epi => AIDS Inst
Multiple Approaches to Program Integration

- **Structural**
  - Pros: Better align major players
  - Cons: can’t be relied on to address all integration issues; reorganization can lead to confusion

- **Collaborative (cross functional)**
  - Pros: Flexible, rapid implementation
  - Cons: not sustainable if not institutionalized

- Both approaches are needed.
“... every time we were beginning to form up into teams we would be reorganized ... I was to learn later in life that we tend to meet any new situation by reorganizing; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralization.”

Petronius Arbiter, 210 B.C.
NYS Approach to Integration

- Active involvement of providers, consumers;
- Leverage multiple funding streams; existing programs;
- Mobilization of other state agencies, systems;
- Open lines of communication;
  - Joint development of messages and materials;
  - Collaboration on funding proposals;
  - Link prevention and care.
- Utilize cross functional teams frequently
Integration Example: Hepatitis

- Focus on hepatitis began without new resources
- Establish widely representative working group meets quarterly
- Joint development of strategic plan
- Given lack of dedicated funding, program components were located where resources exist:
  - Surveillance – with communicable disease
  - Vaccination – piggy-back on existing service settings - STD
  - Link to health care settings – AIDS healthcare program
# Hepatitis Integration 2006

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Center for Community Health</th>
<th>AIDS Institute</th>
<th>Wadsworth Center</th>
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<tr>
<td>Collaborative Planning</td>
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<td>• Meeting with CDC Division of Viral Hepatitis</td>
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<td>• First Annual Meeting of Northeast Hepatitis C Coordinators’ Alliance</td>
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<td>• Viral Hepatitis Strategic Plan</td>
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<td>• Viral Hepatitis Strategic Plan Tracking Document</td>
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<td>• Hep. Integration Work Group</td>
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<td>• Hepatitis A&amp;B Work Group</td>
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<td>• Interagency Meetings</td>
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<td>Developing New Models of Service Delivery</td>
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<td>• Viral Hepatitis Integration Project</td>
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<td>• Primary Care Resolicitation &amp; Montefiore Infectious Disease Clinic</td>
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<td>• Hepatitis C Continuity Program</td>
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<td>Enhancing Service Delivery</td>
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<td>• STD/HIV Hepatitis Integrated Risk Assessment Tool</td>
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<td>• Promotion of Hepatitis C Clinical Guidelines</td>
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Note: 1=Healthcare Epidemiology Program; 2=Immunization Program
Hepatitis Integration Successes

- Hepatitis Integration Project (CDC funded)
  - Builds on co-located HIV Testing/Primary Care in Substance Use Treatment and harm reduction settings
- National Hepatitis Training Center
- Hepatitis A and B Vaccination
  - STD, state corrections, harm reduction sites
- Hepatitis C surveillance and follow up: Communicable Disease
- Hepatitis C Coordinator – AIDS Institute
### Targeting High-Risk Adults for Hepatitis A and B

<table>
<thead>
<tr>
<th>NYSDOH</th>
<th>Local Health Departments</th>
<th>Other Local Agencies and Organizations</th>
<th>Risk Populations</th>
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<tr>
<td>Immunization Program</td>
<td>Immunization Program</td>
<td>MMTP</td>
<td>High-Risk Adults/Adolescents</td>
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<td>Adult Hepatitis Vaccination Program</td>
<td>STD Clinic</td>
<td>County Jails</td>
<td>Injection Drug Users</td>
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<td>TB Clinic</td>
<td>College Health Centers</td>
<td>Incarcerated Persons (Jails)</td>
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<td>HIV C&amp;T Program</td>
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<td>High-Risk College Students</td>
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<td>Other DOH Units:</td>
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<td>Sexually Active Heterosexuals</td>
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<td>BSTDC</td>
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<td>MSM</td>
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<td>BTBC</td>
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<td>Persons at Risk for TB</td>
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<td>AIDS Institute</td>
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<td>Persons at Risk for HIV/AIDS</td>
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<td>Indian Health Program</td>
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<td>Active Injection Drug Users In and Out of Treatment</td>
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<tr>
<td>Migrant &amp; Seasonal Farmworker Immunization Program</td>
<td>Local Health Department Immunization Program</td>
<td>Community Based Health &amp; Human Service Providers</td>
<td>Persons at Risk for HIV/AIDS</td>
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<td>Migrant Health Program</td>
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<td>Indian Health Centers</td>
<td>Native Americans, On and Off Reservations</td>
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<td>Migrant/Seasonal Farm Workers</td>
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Hepatitis Integration Status

- Collaborative approach is successful in the absence of dedicated funds
- Takes advantage of expertise and populations served by various existing units
- Structural changes (move Hep C coordinator to AIDS Institute) included
- Remain open to reorganization in the future as resources become available.
Impediments to Integration

- Different philosophies;
- Organizational separation;
- Limitations of categorical grants;
- Competition for financial resources;
- History of poor relationships;
- Personality conflicts.
Facilitators of Integration

- Communication
- Leadership;
- Realization of shared goals;
- Plan from perspective of the “customer”: patients, clients, providers;
- Identify needed components and build on the different strengths of programs;
- Realize economies of collaboration;
- Organizational connections.
CDC’s Role

- Recognize the need for flexibility to meet local needs;
- Recognize and promote “Models that work”/“Best Practices”;
- Foster interaction among Project Officers in different program areas;
- Consider cross-training, joint site visits;
- Convene joint national conferences or overlap at same locale;
CDC’s Role

- Coordinate with other federal agencies, e.g. substance use;
- Build in integrative goals into cooperative agreements;
- Give data standards and provide flexibility for providing equivalent data;
- Be consistent in definitions/data elements (age, race, etc.);
- Request adequate and stable resources.
Integration must be a broad, organizing principle, even beyond these 4 programs;

Although structural integration may be desirable, collaborative integration must also be practiced.

Integration must be an organizational priority backed by leadership;

Integration can’t overcome inadequate funding.