Operator: Good day and welcome to the Putting Plans into Action: Roles and Responsibilities conference call. Today's call is being recorded. At this time I would like to turn the conference over to Julie Hook. Please go ahead, ma'am.

Julie Hook: Great. Thank you. Good afternoon, everyone, and welcome to this webinar entitled Putting Plans into Action: Roles and Responsibilities for Implementing Integrated HIV Prevention and Care Plans. My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistance Center. And I want to thank everyone for making time to be on this call. Our goal of this webinar is to provide information on different approaches to establish roles, responsibilities, and structures for implementing the 5-year integrated HIV prevention and care plans that you submitted to CDC and HERSA last fall.

We hope that after today you'll be able to identify sound practice models for collaborative, integrated HIV prevention and care plan implementation, understand essential steps in a flexible process to agree on roles and responsibilities for integrated HIV prevention and care plan implementation, identify key questions to answer when choosing a collaborative implementation structure, and assigning roles and responsibilities, and be able to address challenges in integrated HIV prevention and care plan implementation.

We'll be answering questions at the end of the call, and we'll answer as many as time permits. All questions, including those that we don't address during the call will be added to a Q&A document and posted along with the transcript, slides, and a recording of the presentation on the IHAP TA Center page on the TARGET website. So if you have questions during the call, please chat them into the chat feature.

I'm excited to present our presenters today. Emily Gantz McKay is President and Managing Director of EGM Consulting and was previously President of Mosaica. She's been assisting HIV planning bodies, service providers, and health departments since 1987 and has been working with the HIV Bureau since 1994. She'll present on challenges and a flexible process for exploring options and assigning roles and responsibilities, including highlighting some sound practice models from a few jurisdictions.

Stanley Waite is from the Delaware Division of Public Health, the Delaware Ryan White HIV/AIDS program Part D recipient. He's also the government chair of the Delaware HIV planning council and he'll present the approach they are taking in Delaware by implementing their integrated HIV prevention and care plan.

Just as a reminder, the IHAP TA Center is a three year cooperative agreement to support Ryan White HIV/AIDS program, parts A and B recipients and their planning bodies with implementation of the integrated HIV prevention and care plans. And

now I'd like to introduce Michael Goldrosen, director of the division of state HIV/AIDs programs, who'd like to say a few words. Michael.

Michael Goldrosen: Great, thank you, Julie. First of all, welcome everyone, and thanks for joining us today on this webinar. I just wanted to begin by updating you on the collaboration between HERSA's HIV/AIDs bureau's division of state HIV/AIDs program, as well as our partners at the division of Metropolitan HIV/AIDs programs. And the centers for disease control and preventions division of HIV/AIDs prevention. The three of us have been partnering together and wanted to update you on our plans regarding the integrated HIV prevention and care plans, including the state-wide coordinated statement of need.

HERSA's have division of state HIV/AIDs programs and our division of Metropolitan HIV/AIDs programs, as well as the CDC's prevention and division of HIV/AIDs prevention. Across all of the different recipients and jurisdictions, we have received 80 integrated HIV prevention and care plans, including the state-wide coordinated statement of needs that have come in. We have conducted jointly these sessions, of those integrated HIV prevention and care plans, during March of 2017. This involved folks across all the different departments. So right now, in terms of where we are in the process, the CDC and HERSA are finalizing the jointly made summaries and are planning a phase joint feedback process to all of the jurisdictions that submitted plans.

There's been a lot of great discussion by both CDC and HERSA project officers who took part in the joint reviews about each of the integrated plans. Both agencies are now going through the process of reading through all that discussion and material in order to finalize our joint [inaudible 00:04:49] summaries. Despite the fact that we don't have those summaries back to you yet, we want to encourage all of you to continue with your integrated planning activities. Your plans are living documents and it's our expectation that collaborations across HIV prevention care and treatment service delivery systems continue beyond the simple submission of the plan itself, including the state-wide coordinated statement of need. The IHAP TA Center, who's conducting this webinar, is one of those resources that we hope will assist all jurisdictions in your ongoing integrated planning activities.

So this is why we are particularly excited about the IHAP TA Center's webinar series. This is the first one, the webinar today, around putting plans into action: roles and responsibilities for implementing integrated HIV prevention and care plans, marks just one of the virtual learning opportunities and TA tools that the IHAP TA Center, has multiple, will provide to support the ongoing integrated planning activities across the continue of HIV prevention care and treatment delivery systems. So therefore, without further ado, I'll turn it back over to Emily Gantz McKay, to take us through the rest of the webinar.

Emily Gantz McKay: Thank you, Michael. I am delighted to help you all in any way we can with speaking about this process and moving it forward in a reasonably structured way, and building on all of your experiences. We thought first you'd like to see what the plans look like. There were a total of 80 plans submitted, covering, on the care side,

109 jurisdictions. Every one of those plans was an integrated prevention and care plan. Almost half were integrated part B only plans, and of those, 29 were from states and territories that don't have any part A jurisdictions, and eight were from places that do have part A jurisdictions, but the part A's submitted their integrated plans for prevention and care, but not with part B. There were 21 integrated part A only plans. Of the 21, about a quarter of all the plans, 12 of them from eligible metropolitan areas and nine of them from transitional grant areas. And then there were 22 plans that are part A, part B, and prevention. So that's the total, of 80 plans that are being reviewed now and that you're all going to be implementing over the next five years.

We thought it would be helpful to get a sense from you of where you are in the process. So we have a little poll here and we are asking you to say what is the status of your integrated prevention and care plans. You can select all the responses that apply. What are you currently doing? And you may be doing more than one task. Please enter that now.

I'll give you another 10 seconds or so. So please push the submit when you are done. Okay. I think we've got responses, so we want to close the poll. So, half of you said you're waiting for feedback. A little over half said you're already implementing the plan and somewhere in the range of a third of you are involved in setting up monitoring. The rest of you, about a third, say you're exploring collaboration, you're assigning responsibilities, and you're documenting rules and processes. All very good activities that we are very happy to see.

One other thing I want to make sure we have as background as we move forward, many of you will remember and some of you, hopefully, have used, a matrix that was attached to the guidance for the integrated plan when it came out, almost two years ago now. It listed and described ... had examples of a number of different ways that prevention and care cooperation can happen. If you look at this chart, it really goes from the less complex to the more complex as you move up the chart, up the list. Information sharing, cross representation, so there are numbers that are on both bodies. Prevention and care, joint activities like frequently needs assessment. That plan right in the middle. Now, you've got a plan. And then there are integrated committees, which you'll hear more about in some of the sound practices, where they're two planning bodies, or three, but they are working together to a steering committee or some kind of joint planning group.

There are a number of unified planning bodies and we did an assessment for the division of metropolitan HIV/AIDs programs in 2016. At that time, we found nine part A unified planning bodies and there are many more at the state level. A few of the unified planning bodies not only work with prevention and care, but they also are involved with housing opportunities for people living with HIV and AIDs and or other STDs. For example, the Chicago integrated planning body is involved in housing planning as well. All of those are things that are roles you may consider in collaboration as you implement your plan.

With no more discussion there, also, if you see an asterisk, that asterisk means that

those activities are relevant when you're doing part A, B, C, collaboration across parts, as well a collaboration between prevention and care. Now we want to begin by having a presentation from Delaware. And I'm going to hand off to Stanley Wait, who, again, is the part B program administrator, the recipient for part B, on how they did their planning and how they are going to implement their plan together.

Stanley Waite: Thanks, Emily. Hi, I'm Stanley Wait. I'm the Ryan White Part B Program Administrator for the Division of Public Health in Delaware. Along with me, I have Tyler Bell from the Delaware HIV consortium and Glen Pruitt from Seven Keys Consulting. Planning to make a difference, Delaware's efforts to implement an integrated HIV prevention and care plan. Before I get to the next slide, I'll give you a brief history of the community planning council.

In 2013, the community planning group was, for a lack of a better word, broken. The contract funding was reduced. There wasn't a full STD position dedicated to this contract. The planning council members that are still involved or that their opinion was valued. At that time, I volunteered to manage the contract going forward. I became the government coacher of the planning council. The first step in restructuring the HIV planning council was requesting technical assistance from my host of project officer.

In July of 2014, Emily Gantz McKay of EMG consulting provided two days of onsite technical assistance. The Ryan White grant series, HIV prevention staff, and planning council members attending that two day onsite training. As a result of the TA, the following was agreed upon by all attendants to start the process of rebuilding the HIV planning council.

A firm commitment from the Delaware Division of Public Health to respect the community planning process. A firm commitment from the Delaware Division of Public Health to fund the community planning process. This is being funded by HIV prevention dollars and rebuild dollars. Clearly define roles and expectations for grant use in the Delaware HIV planning council. A restructuring of the planning council to merit a gardener cash gain.

On this slide, you'll see the [inaudible 00:13:12] chart for the HIV planning council. You'll see HERSA, Ryan White Part B, and CDC HIV prevention up top, which is blended together at the Division of Public Health level. Bob Vela is the HIV prevention administrator and I'm the grantee for the Ryan White Part B program. When I see blended, I mean Bob and I work together on a daily basis and we're in the same section at Public Health. Our offices are right next to each other. So we see each other every day. The HIV planning council contract is managed by Tyler Bell from the Delaware HIV consortium.

The HIV planning council can have up to 35 voting members. The executive committee is made up of two community co-chairs and one government co-chair. There are also five working groups within the planning council. We have the membership and community engagement, testing and linkage to care, retention involves suppression, systems of care, and the positive acting committee. Each of

these groups have a champion who is the lead person for that work group.

The plan review committee, which is shared by Glen Pruitt from Seven Keys consulting, he is the Ryan White Part B quality management contractor. This committee is composed of five members. The Ryan White grantee, HIV prevention program administrator, HIV surveillance program administrator, the manager of the HIV/AIDs community planning contract, and the Ryan White Part B quality assurance consultant. This committee meets three times a year. This committee reviews the progress made with each activity included in the plan. I believe this plan has a total of 84 activities. Then we engage in problem solving if any activity has faltered or encountered unexpected barriers.

The Delaware HIV planning council. Council members are active participants in the development of the integrated plan, which equals community buy in, which is what we were looking for. HPC work groups, they're classed with several activities in the integrative plan itself. The council receives a progress report from the plan review committee twice a year, which would be in May and November. So we just gave an update yesterday to the planning council members, well received. From these progress reports, highlight successes in implementing of the plan. Identifies challenges encountered with specific activities and will provide an opportunity for the council to engage in problem solving, or to suggest modifications to the plan.

Delaware's integrated plan is a living document, responsive to an evolving healthcare landscape and fiscal environment to answer community input. Which means this plan isn't going to be put on the shelf. It's a plan that we're going to use on a daily basis, so we're going to work this plan.

Lessons learned so far. Affirm the value of community input, big and small roles. Many [inaudible 00:16:16] numbers want to have their say in HIV prevention and care planning. So far, few are willing or able to step up and do the work. Allow plenty of time for everything. Show almost everyone involved how to implement the plan is a learning curve. But the most important thing is not the plan. The most important thing is mobilizing our systems and our community to make a difference in the HIV/AIDs epidemic in our state. Thank you.

Emily Gantz McKay: Okay. We'd like to give you a little information from a couple of other plans and jurisdictions that developed them that we think are sound practice but that are different. The one you have just heard from is a part B prevention only, state level plan. And we'd like to show you a little bit about what was done in Indianapolis and Indiana. That is a joint part A, part B prevention plan. It was developed through a steering committee and five working groups. Each of which had as members recipients, staff of the recipients, members of the part A planning council, the part B, called CHISPAC, comprehensive HIV services planning advisory council. And the community planning group. And strong consumer participation. These five work groups dealt with different parts of the plan, from one on needs assessment to one on monitoring improvement. The plan was developed jointly. When it was completed, it was agreed that the state will to serve as the leadership for joint implementation committee, which is going to look pretty much similar to the

steering committee.

Again, my information comes from Michael Wallace, who's the part A recipient in Indianapolis. That membership will be very careful to include representation of the planning bodies and consumers as well. The decision on how to implement the plan was in part A. Those activities that are part A's responsibility. The clinical quality management committee within the planning council is going to coordinate implementation. It will be representative, will send people to that implementation committee. In addition, it is our understanding that the state has decided that it will be merging the part B and the prevention planning bodies into a single planning body at the state level, which of course will be assisting with the implementation and be the link from that side. There we have integrated development of the plan, integrated implementation of the plan, and specific entities responsible in each of the planning groups.

Houston is the third example. Houston is a large EMA and it has direct funding for prevention, because of its size. Its plan is a prevention part A plan and follows the part B ... It is not part of the part B overall state plan, the Texas state plan. It had a great deal of cooperation from the state in its development. Texas has a decentralized system for managing the part B program, so there are seven administrative agencies, one of which is located in Houston and the resource group, which is a non-profit. And the resource group is regularly at the planning council, because the planning council serves as the planning body for part B in the Houston area. Therefore, part A and part B were involved in the development on that regional level, along with prevention.

I should note that the plan was developed jointly by a leadership team of prevention and care recipients and planning body representatives, other community members and providers staff. It also had four work groups that were designed to focus on areas of special concern in the content of the plan, like working with special populations, targeting special populations. There's also an evaluation and monitoring work group that focused on developing that section of the plan.

In terms of implementing the plan now that it is developed, there will be independent implementation by each entity. I should note that one of the interesting aspects of Houston is that the prevention recipient is the city health department. The care part A recipient is Harris County. So they're different agencies, although located both in the Houston area, of course. What they decided is that there will be implementation individually and staff will serve as communication liaisons. And there will be quarterly reports developed and shared across the planning bodies. That evaluation work group, which is involved in developing that section of the plan is also going to continue as a joint body.

Structurally, it's going to be located under the planning council's comprehensive HIV planning committee, but it will still have joint membership, as it did during the development phase. It will be responsible for ongoing review of progress on the plan, an annual evaluation report, and review of proposed plan updates. If you

have a joint plan, you need to have collaborative work on the updates. So this is a plan where there is more independent implementation, but the monitoring is together and there is regular communications. Quarterly reports are being developed and shared so that everybody knows what everybody else is doing. So those are three different but sound practice models for implementing the plans.

We thought it would be helpful ... our main purpose in this call is to help you with implementation and really thinking about what will be the roles and responsibilities and the structures used to organize and implement this plan. So there's some key challenges and some key questions that we think it helps to deal with. But first we'd like to say, what are your key concerns? We have one more poll and the question is what are your key concerns and challenges for implementing your integrated HIV prevention and care program? Please pick three. We hope you don't have horribly large numbers, but pick the top three. If everything isn't in that list, [inaudible 00:22:53] on roles, prevention care collaboration, part A, part B, monitoring progress, reaching goals, planning as an ongoing focus, certain external factors, and you've got another, please type it into the chat box so we will know that it is a concern that you have that we didn't identify. Please respond.

My, you're quick. I'll give you about another five or six seconds. You seem to be getting very close to being done. Okay, we'll close poll and say the thing that you seem to be most concerned about is monitoring plan progress. Putting that into place. And I noticed, also, on the first poll, that a lot of folks said that developing those monitoring plans was a concern. And you're absolutely right, it's certainly a major concern. And the other one that's most frequently noted is prevention and care collaboration. For many of you, this is the first integrated plan, so naturally that needs to be developed. And then there are quite a few people talking about reaching goals, making the plan an ongoing focus, and uncertainty, the external kinds of uncertainty. And slightly less agreement on roles and part A and B collaboration. And of course, we think agreement on roles helps you on all of the other things.

Okay, so what are the challenges that ... how we look at these challenges, which are very consistent with things that you said. This is a five year plan and it has new expectations around implementation and updates. Now, the folks from HIV prevention are used to doing five year plans, but those of us on the care side have typically had three year comprehensive plans and not always a regular process that says every year we're going to update them. There's a new expectation around those plans really being central to the work of the recipient and the planning body. And that there will be updates. And of course those goals and objectives are much more closely linked this time to the national HIV/AIDs strategy, and of course the major points on the HIV care continuum. Or some of you call it the gardener's cascade.

You'll have multiple partners, sometimes new relationships. Some of those will be cross prevention and care or A and B or parts. And also some of them will simply be because you may have broadened what you're intending to do. You'll be working with groups you didn't work with before. There are now, presumably, individual

and collaborative strategies and you're going to need to coordinate both doing the tasks and making sure that everybody does their part so that tasks get completed. We also don't want to underestimate the challenges of collaborations among entities, particularly when we're talking about part A, which has very clear planning council legislative responsibilities. And prevention, which has very clear responsibilities, often, but they're not legislatively tied to a calendar in the same sense that many prevention people have said as they were merging bodies and working together. You constantly are looking at the calendar. We're used to dealing at a different level, looking at prevention models, looking at improving targeting, seeing what's happening with prep. Both of those things are hugely important, but the way they're approached has been different, because the responsibilities and the planning bodies are different. We know that that's a challenge as you work together.

Also, people have said sometimes when we're not used to working together we're afraid ... Prevention folks have said we're concerned that if there's more money on the care side, they get more attention. We've heard on the other side that sometimes the staff have more experience with prevention, so we're afraid they won't know what to do with care. Everybody is concerned about making sure that their responsibilities in their areas are fully covered, and making sure that the whole range of activities and the whole range of responsibilities is appropriately dealt with in this collaborative effort.

And of course, we all face external uncertainties anytime you have annual appropriations and lots of changes always occurring in the external environment. Those are challenges. How do you deal with them? We do think within your own planning body and within the recipient that this is a time to think and discuss about how is that plan and how are the raised expectations, perhaps, about using that plan, needing to affect all aspects of your planning. It needs to be a central activity. Looking at it, implementing it, refining it. That probably means adjusting structures and processes and we've had a number of folks who have revised the committees to more closely follow the HIV care consortium or otherwise adjusted their structures to deal with the new plan and the new goals and objectives that they've developed.

It is also a very important issue to know who's going to be responsible, not only for implementation, but for monitoring. You're going to add this on top of ... if you're on the HIV care side, the performance measures. And also the measures related to the HIV care consortium and the NHAS goals around reducing each stage of infection, and getting people into care quickly, and getting them virally suppressed. Delaware used to do this, I don't know if they still have a committee that does it. It is very helpful not to just say, well, the recipient will deal with this or group X will deal with this, but to know who is responsible within your planning body and your recipient together to be kind of an early warning system, an early identification process, to say something is changing, we're going to need to change what we do and we may need to revise our plan.

The opioid addiction has led to large numbers of HIV cases that didn't exist in

certain rural areas before. There may be change in your epidemic. There may be a change in provider structure. Money from other agencies that was used for substance abuse, might suddenly go away. More money might come in. Planning for change is extremely helpful in managing challenges. We also think there are a couple of key, three at least, there are probably more, that will be specific to you, but some key questions that you're going to need to deal with around collaboration. Part of it is going to be, you need to learn from the experiences you had during plan development. If you had collaboration that worked really well, you're going to want to follow on using some of those methods. If there were concerns, discuss them directly as you think about roles and processes. Don't just hope it will get better when you do it more.

Consider rules of engagement. One of the big things that people have talked about is making sure everyone feels that prevention and care are equal partners. And another is changing some of the definitions and being clear about definitions like consumers, which may mean different things in prevention than they do in care. Also include in your collaboration, ask questions about how to do this and resolve them, so that if there are problems, you don't let them fester. You don't let them slow you down. You have a process for dealing with them and moving on to be effective.

We also think you need to answer these questions: what is your desired level of collaboration on plan implementation? You shouldn't be doing it because somebody's pushing you. You should be doing it because it will give you more effective implementation of your plan and more success in dealing with this epidemic. There's no one right answer, but it needs to be thought about. What should you be doing together? Think about it.

Another one is, and this is very important, particularly, I think, in some of the part A, part B collaborative plan implementations, what would be the roles and the level of engagement of a planning body versus the staff? I think the Delaware folks had mentioned that as well. For example, in part A programs, the planning council has been a lead on comprehensive planning. It is a legislative responsibility. When you are doing a plan that's prevention care and A and B, there are representatives from all the planning bodies and all the recipients who get together. In some places, we have heard that there's been some reduction in the level of engagement of the planning council in some aspects of plan development. It's really important that there be a sense that it's their plan. It's everybody's plan. And that we are all going to be involved in the implementation and being really clear what will be done through committees or through the planning bodies, what will be done by recipients, and what by either recipient or planning body staff.

And finally, if you've got a collaborative structure that you've used in the past or you used for developing the plan, can you perhaps continue to use that for implementation ... Something similar is being done in Indiana for example. Or you need a new structure. There's no right answer, but think about those things.

We have developed six steps for agreeing on roles, responsibilities, and structure.

They are not magic. But they are things that it may be easier for you to use than to not use and wish you had used later. It's an idea of saying let's think about these things in a couple of good, solid meetings at this stage. And that includes things about who's responsible for monitoring, which you all say is a priority. Then we won't be trying to figure it out a year from now when things aren't working as we want. Planning is valuable. Think about these things ahead of time.

The first is fairly obvious, but also very important and that is review your plan. It has been seven and a half months since most of you developed those plans. Sometimes a little more. You have a chart. In the work plan, we think, that has activities and probably who's responsible. At least, that's something that was in the guidance. You want to look at having an entity that is responsible for each activity. If there's not one entity, if it's shared, who's coordinating? If there are activities that require prevention and care to work together, or part A and B to work together, what are those activities and is it clear who's doing what?

Second, really carefully review your responsibilities for monitoring improvement. There are a lot of pieces in there, like collecting information, like analyzing the information, sharing at a cross prevention and care, sharing at across parts, if it's an A/B plan. Make sure there is clarity and people really have the time and skills and resources to do that.

Also, if there are needs for changes in the plan, don't wait until the end of the year and then say, "Gee, we didn't implement that because it didn't work. But we should've done something else." Really think about making those changes promptly.

Second, identify key roles. And here, I really am saying think about that fact that, especially an integrated plan, you are not only looking at roles for implementing strategies and activities, you're thinking about a lot of other roles that have to happen to make the implementation work. So it's what are the key roles that have to be assigned? They include, again, coordination of shared activities. Is that a staff function, are there certain committees that will do it? What will be the communication among entities for things that are being done largely independently but affect each other. How is the data going to be gathered to assess progress? How is it going to be analyzed? Some people currently do it once a year. You probably want it done more often, if you're collaborating, and you want to make changes in your plan. You want to have a clear review of monitoring data, and I think that's why you find in a lot of our sound practices that there was a joint monitoring. A joint committee that was going to monitor. Even if they weren't doing implementation so much together, they were going to monitor together, because we have to be able to make revisions and refinements. That needs to be done across the entities that were parties to the integrated plan.

There needs to be annual evaluation, both to see how you're doing with your goals and to see if you need to be updating your plans. And there are a few places that did integrated plans where they literally did a plan for A and a plan for B and a plan for prevention and they put them in the same folder, but they were largely

independent except for a few shared tasks. Many of them are much more integrated than that. If they are integrated, the updating of your plans also is going to have to be done collaboratively. Think about how that will be done. It does take longer to do things collaboratively, even though it's better.

And then, again, the total level of collaboration from "we do it independently, but we meet periodically" to "we're going to do it in an integrated way". There is no right answer for whether it should be primarily reporting specific strategies, everything. But do consider carefully what works best for you. Part of that has to do with what your plan looks like. Part of it has to do with resources and location. Do consider both existing and new structures. This is a little bit of what you heard with sound practice. An integrated planning body, a joint implementation committee, joint work groups, some of which were involved in development of the plan and now can be involved in implementation. Some kind of monitoring committee. And also you may want to give assignments to different committees that exist or expand them, so you have people from two planning bodies in some integrated committee. Or, start a new committee or new sub-committee. Any of those is fine. Certainly where you can use an existing structure, it does save you some time. But if the existing structure didn't work, then you don't want to put more pressure upon it. If it was challenged, then you need to modify it.

Finally, then, you need to assign and document. That means agreeing on those structures, specifying roles and responsibilities and boundaries. I do think that boundaries, we've found, are very important. For example, you have a group that's working on a needs assessment task. Are they decision makers about the resources to be used? Or do they have to go back to certain things? Can a work group make decisions for the planning bodies, or do they make recommendations back to the planning body? Or, if it's an advisory body, back to the recipient? And how will that be done so that you don't create ... and we've seen it happen, and people then have to restructure, which is fine. Make sure people know what they are supposed to do and what that group is not assigned to do. Where are the boundaries in their work?

And also think really carefully about membership. I think folks in general will say recipient staff and planning body representatives, but you also want to make sure that if they're planning body representatives, they include consumers and prevention and care services and provider representation. The prevention folks have tended to do awfully well. Sometimes we do it equally well on the care side and sometimes not, to bring in other experts. And particularly with the challenges of monitoring and improvement and the wide range of things that an integrated plan deals with. University representation, researcher representation is very important, education and business representation can be very important. People who know a lot about public or private insurance can be really important. Think really carefully about bringing the right people in, the stakeholders, early in the process.

In addition, when you make decisions, make sure that what is included in the "Here's what the process is" it says you make these decisions, you make

recommendations on these things, here are the final decision makers. Again, we suggest you decide. When you decide, you develop and approve processes that you use to implement. We don't need pages and pages, but we need something written that everyone will see, so everyone will start out, at least, with a common understanding of what the roles and responsibilities are and there is clarity on who is responsible at the staff level, both planning body staff and recipient staff to make these things happen. This sounds very logical, but we have found that often people are in a hurry and they're feeling late because it's already May. If you don't think about these things carefully, people do tend to have different assumptions and you'll have to deal with them later.

So document what you decide, even though you know that you're going to implement, review, and refine. One of the things, and I am prejudiced because I was involved in the process, but I thought one of the smartest things that they decided to do in Indianapolis and Indiana, when they started the joint planning process, was to bring together people from all three of the planning bodies. And they had people volunteer for their five work groups. They got everybody in together to train them on what they were going to do, what the processes were, what the agreements were, who was going to do what, how decisions would be made, and everybody started out with a common understanding.

We also think the experience, especially with the first integrated plan. For some of you, it's not your first integrated plan, but for a lot of folks, you're doing this for the first time. Agree on quarterly tasks and really do review progress and challenges, both in a process sense and in a how are we doing in implementing this activity. Review quarterly so that you can make changes if you need to, if you made a mistake. You've got a work group but it's missing some skill that it needs. Or something is not working because it's too demanding for the members of the work group or the committee. Think about those things really carefully quarterly for the first year at least. Then fully assess your progress and your process at the end of the year. Not only progress towards your goals and objectives, but how your process is working. One of the things that we have found most helpful ... I'm old. In my work of this type and the work of the folks that I work most closely with is make sure you don't just talk to the leadership, but you talk to the members of those committees. The members of those committee bodies to say how are we doing and what could we do better so that we can be more effective in implementing this plan.

Because this plan is really important in making a difference in the epidemic in our area. Again, refine structures, and roles and responsibilities as you need to. Make that an ongoing process. Again, these are not magic. Many of you will have thought of most of them and maybe all of them, but it can be helpful, especially when you're working with prevention and care or A/B in prevention for the first time in implementing and plan to make sure that we all are making the same assumptions and that we're making decisions jointly.

So those are our suggestions and I think we're now back to Julie for questions. I apologize, I'm supposed to do this. I wanted just to tell you that there are some

very helpful tools around that you could use. Houston's done them spectacularly. It isn't that it is magic. But if you have some good charts that summarize your progress and your work plan … each committee that's involved, that has responsibilities, has a work plan that defines those responsibilities and at a deadline, especially since the work of one work group or committee may lead to other options for another work group. And if we're not going to get it done then the whole chain gets messed up.

If you do those things and you do a progress chart, those kinds of things, developed early, can be used throughout the entire process, for the next five years. You will not be trying to figure out what you did month three or month 12 because you will have that documented. The progress chart idea is sort of a, "Here's what we have to do. Here's who's responsible. Here's how we said we were going to do it. Here are the resources." And a check off for progress every quarter. In Houston, they use that to develop their quarterly reports, but it will help you if you've got those quick charts based on your work plan from the plan that will help you bring together work that's being done by a number of different entities and a number of different work groups or committees within those entities.

Now I'm really done and it's time for questions.

Julie Hook: Great, thanks, Emily. Thanks, Stanley. If you have any questions for either Emily or Stanley and his team, you can please chat them into the chat box. There have been a couple questions that have come in that I know Stanley and his team have answered, but I'm going to go ahead and read those and have them answer them for those of you who may have not seen them. So this question is for Tyler, from Delaware. Who reports the progress on the plan activities to the plan review committee? How do you track activities on progress and does the twice annual review of progress include review of surveillance data?

Tyler Bell: Great. Hi, this is Tyler. I provide staff support to the Delaware HIV planning council. I manage the day to day operations of our group. As Stanley was saying earlier, we have a plan review committee which is run by our Ryan White quality assurance member. It is made up of five individuals who all essentially are the leads of prevention, care, surveillance, the planning council, and the quality assurance team. Like also Stanley was saying, the Delaware HIV planning integrated plan had about 84 activities in it. The five members on the plan review team broke those 84 activities up into groups. Each of the five members had different groups that they were responsible for being the lead on to ensure that progress was being made on all 84 of those activities. Those individuals were responsible for getting in contact with the other members of the community that need to do baby steps to get those activities completed on time.

The other part of that, in Delaware we're lucky that HIV prevention, care, and surveillance all work hand in hand with each other. Like Stanley was saying, they're right next door to each other at the Division of Public Health. But they also work hand in hand with the planning council, in that they're voting members and they also sit in and actively participate in our working groups. So, we're constantly

looking at data along every step along the way. Our community members are constantly being updated on the activities, the surveillance. And the data that is coming out from this Division of Public Health. It is constantly being reviewed and assessed. Does that help answer the question?

Julie Hook: Yes, great, thanks, Tyler. Another question for your team. Stanley, there's a question that you also answered, but a question about whether or not there were consumers at large on the plan review committee.

Tyler Bell: Right, so one member of our executive committee is a person living with HIV, and we set up our bylaws to ensure that that would occur. At the same time, we also have one of our working groups is our positive action committee, which is solely made up of people living with HIV. This is a recently added working group, but it was really to empower people living with HIV to become actively engaged in the community planning process and become advocates for their community throughout the state. We regularly meet monthly with about 15 to 20 people living with HIV across the state, coming together. That has facilitated a full third of our planning council, which is people living with HIV, making decisions for themselves.

Julie Hook: Great, thank you. Emily, there's a question for you that's specific about Houston. Were the prevention activities administered at the city level and the care preventions administered at the Harris County level?

Emily Gantz McKay : I don't know if you're talking about the planning process or the implementation. The implementation will be done primarily within the two recipients as I understand it. We can certainly get more information from Amber Harbolt, the planner, who can tell us more. But the development of the plan, those work groups, were made up of people from both prevention and care. The plan was developed jointly with those work groups and the steering group. It was very much a joint plan development process.

Julie Hook: Great, thanks, Emily. If you have any last questions, please chat them into the chat box. I did want to mention that we have another webinar coming up soon, next month on Strategies and Lessons Learned for Consumer and Stakeholder Engagement in Integrated HIV Prevention and Care Planning and Implementation. So we'll be sending out an email through our listserv with details soon. It looks like we have no other additional questions that we can answer at this time. Please contact us at IHAPTAC@jfi.com to obtain more information or join our mailing list or to share your experience. We'd also love to hear from you about what kinds of resources or tools may be helpful to your jurisdictions as you're implementing your integrated HIV prevention and care plans. We'd love to hear about what kind of support we can offer you.

So as a reminder, an evaluation will pop up on your screen in a moment. Please fill out this evaluation, as it helps us to plan additional webinars and resources. Thanks for your participation.