Collaborative Planning Workgroup (CPW)

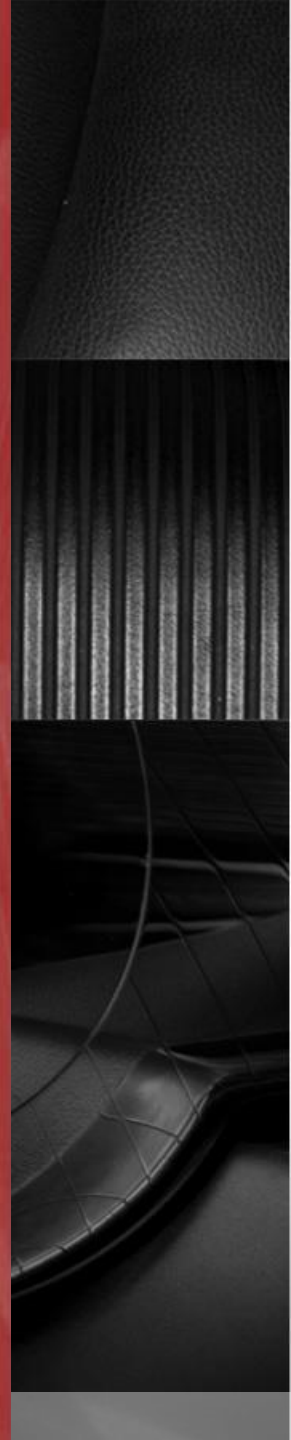
Collaborative Model Recommendations

Presentation to:

HHSPC and HPPC Joint Council Meeting
October 28, 2013

Presentation by:

Andrew Lopez
Laura Thomas
Michael DeMayo



Overview

- Collaborative Planning Workgroup (CPW) Summary of Operations
- Introduction of Motion
- Presentation of Collaborative Planning Models
- Discussion and Questions

CPW – Background

- The framework for a collaborative planning workgroup was developed in September 2012 by representatives from both councils at a special meeting.
- Operating Agreements between HPPC and HHSPC to form a Collaborative Planning Workgroup (CPW) were then drafted and approved by both Council's in January 2013.
- A consultant was hired in February 2013 to facilitate the CPW process of developing a framework for increased collaboration between HPPC and HHSPC.
- CPW begins meeting in February 2013.

CPW - Background

The CPW was charged with creating recommendations for both councils on how the councils can more effectively work together.

"The mission of the workgroup is to ensure a continuum of HIV services for community members at risk for and living with HIV by planning increased council collaboration."

Learn more at SFHIV: https://www.sfhiv.org/

CPW - Background

The CPW was **not** charged to:

1. Recommend specific by-law changes

2. Develop an implementation workplan or timeline

CPW - Background

- The CPW met a total of 7 times between February and September.
- One full-day retreat was scheduled in June where intensive work on developing several models was completed.
- The CPW reviewed the work of each council, larger systems of both care and prevention, collaborative efforts happening nationally, and a review of current collaborative model frameworks to help guide the development of a San Francisco specific model.
- The CPW acknowledges that current mandates from HRSA and CDC will not be affected by adoption of either model being recommended today.

Detailed summaries of each meeting and the work of the CPW is in the appendix to this presentation.

Motion

Recommend to adopt Model 1 – Time Phased Full Integration

Collaborative Model Presentation

Andrew Lopez
Laura Thomas

Benefits and Challenges of Collaboration

Benefits

- Allows development of a common mission and vision
- Encourages sharing of knowledge and data
- Combines and maximizes limited resources
- Reduces planning costs in the long term
- Creates comprehensive services/ encourages linkage of services
- Fosters integration

Challenges

- Integrated By-Laws (Name of Group, Quorum, Terms, etc)
- Synchronize planning cycles/ budget planning
- Respectful transition of current members
- Meeting schedules
- Ensure prevention is not obscured with integration, or vice-versa
- Jurisdictional difference

First Set of Models Selected

Time-Phased Integration

- Full integration over 2 year period
- Begin with Joint Executive Committee
- Form prevention/care workgroups
- Develop goals and objectives related to integration

Shared Leadership

- Leadership of both councils would form one committee to share leadership
- Shared responsibility for deliverables
- Gradual, incremental change
- Evaluate after one year

Full Integration

- The councils would be dissolved and a new council would be created
- By dissolving both, one council is not absorbing the other

Final Models Approved by CPW

Time-Phased Full Integration

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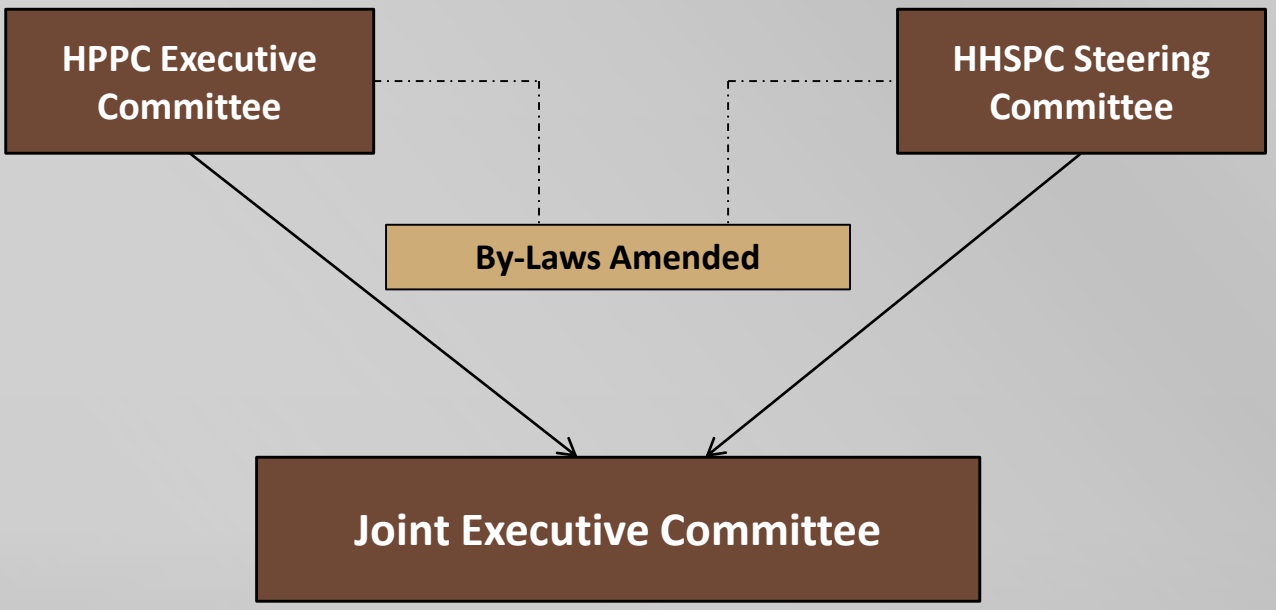
Model 1
Time-Phased Full Integration

Pre-Planning Phase
(3 months)

The by-laws of both the HPPC and HHSPC are amended to allow for the creation of a joint Executive



Planning Phase I
(6 months)

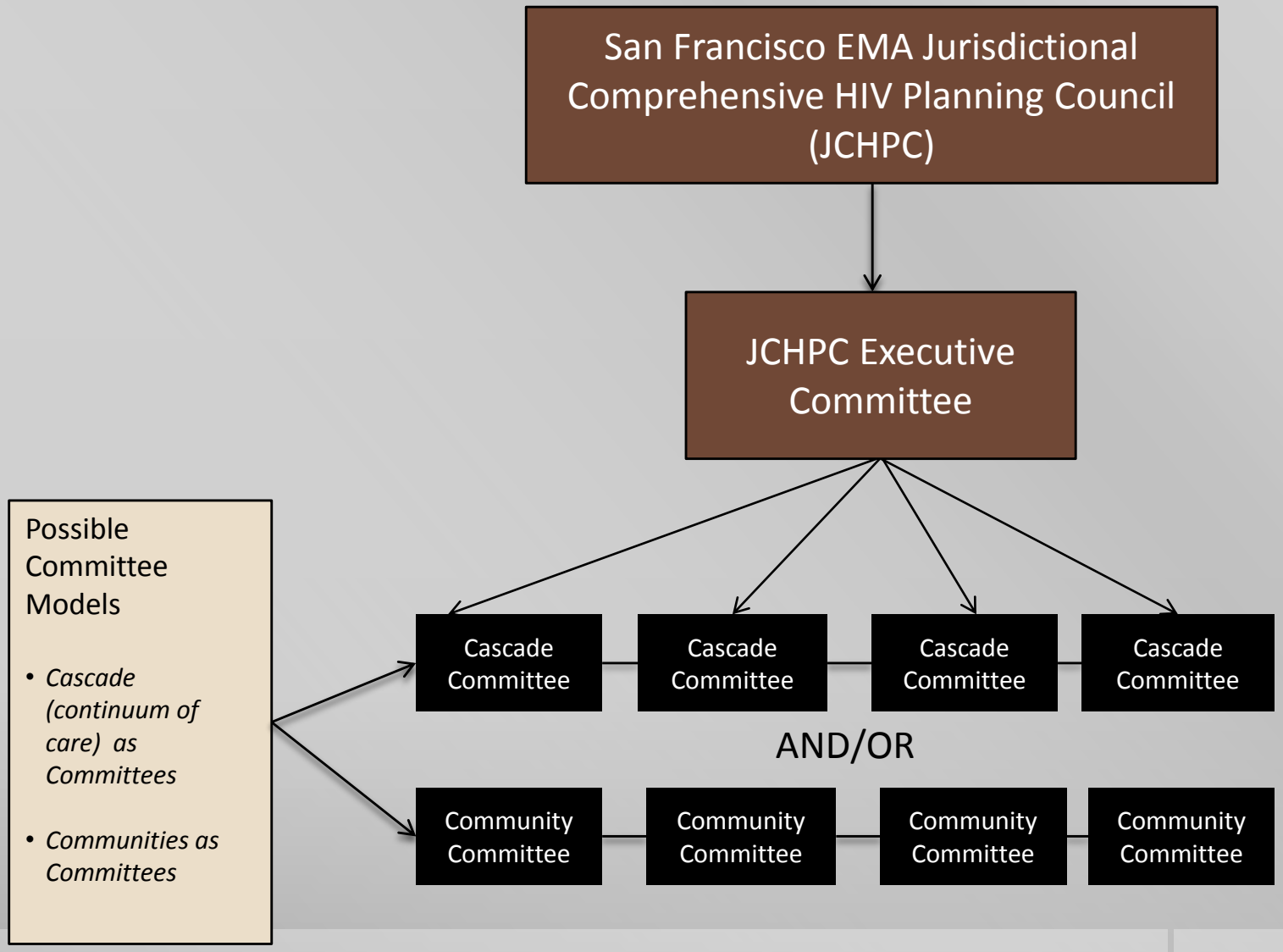
- Plan for integration is developed.
- HPPC and HHSPC meet independently and continue mandated activities.

Planning Phase II
(12 – 18 months)

- New membership applications are distributed to all current HPPC and HHSPC council members.
- Membership applications are evaluated and new member acceptance letters are delivered with committee and workgroup assignments.
- The HPPC and HHSPC are dissolved.

Integration Phase
(2 years)

The new council, tentatively named *San Francisco EMA Jurisdictional Comprehensive HIV Planning Council* begins meeting.



San Francisco EMA Jurisdictional Comprehensive HIV Planning Council

Vision/Mission	Guiding Principles
San Francisco is a place where new HIV transmission is rare and when it does occur, that everyone has unfettered access to high quality, life-extending care regardless of sexual orientation, age, gender identity, race/ethnicity or socio-economic status free from stigma and discrimination	1. Full equity in structure; one council not absorbing the other 2. Mindful of structure and histories of original councils 3. Value consumer/PLWHA in leadership and membership 4. Community speaking w/ multilingual voice 5. Embrace efficiency to improve health outcomes as the health care system evolves and additional responsibilities become clear 6. NHAS, ACA, Ryan White and primary prevention will guide the work of the council 7. Most council work to be done in committee or workgroups

San Francisco EMA Jurisdictional Comprehensive HIV Planning Council

STRUCTURE
Membership: Migrate from current structure and assess external regulations; one-third of unaffiliated members should be PLWHA; merge all mandatory roles
By-Laws: Defer to a TBD process during the planning phase of integration
Products: All existing products and merge where applicable; primary prevention statement; SF statement on behalf of council
Committees/Workgroups: Defer to a TBD process during the planning phase of integration
Administrative Mechanism: Continuity of staff during transition; eventual RFP for administrative staff (non-governmental) to work with the integrated council
Governance: Incorporate both government models of co-chairs and at-large members.
Reconcile Roles: Work together towards requirements of CDC and HRSA

Strengths and weaknesses

Strengths:

- Reflects what is already happening at agency/ community level
- Optimizes services
  - *Better communication, outreach and education*
  - *Improved/streamlined coordination*
  - *Decrease unnecessary duplication*
- Better stewardship of funding
  - *Management and maximization of $*
  - *Reflects the organizational level reality of receiving both care and prevention $*
- Simplified administration
- Increased ability to track services
  - *Monitor outcomes*
- Adaptability and flexibility
- Removes barriers between HIV+ and HIV- individuals
- Integration acknowledges the holistic experience of the individual receiving services – prevention and care integrated into a seamless delivery system

Weaknesses:

- Bureaucratic and size
- Doing both tasks required by councils
- Determining which tasks are care or prevention and what can be continued

Challenges

Technical:

- Possible reduction in the number of seats and change in term limits
- Maintaining parity, inclusion, and representation
- Potential for diminished advocacy
- Complicated administrative deadlines
- Executive/Steering tasked with a heavy workload during first year
- Changes to by-laws that reflect needs of both care and prevention
- Leadership
- Completing the required and mandated work of both councils.

Adaptive:

- Maintaining the culture of both councils while developing a new culture that reflects a new model of planning
- Focusing on the whole system, not just one part
- Council members will have new responsibilities and a steep learning curve during the transition

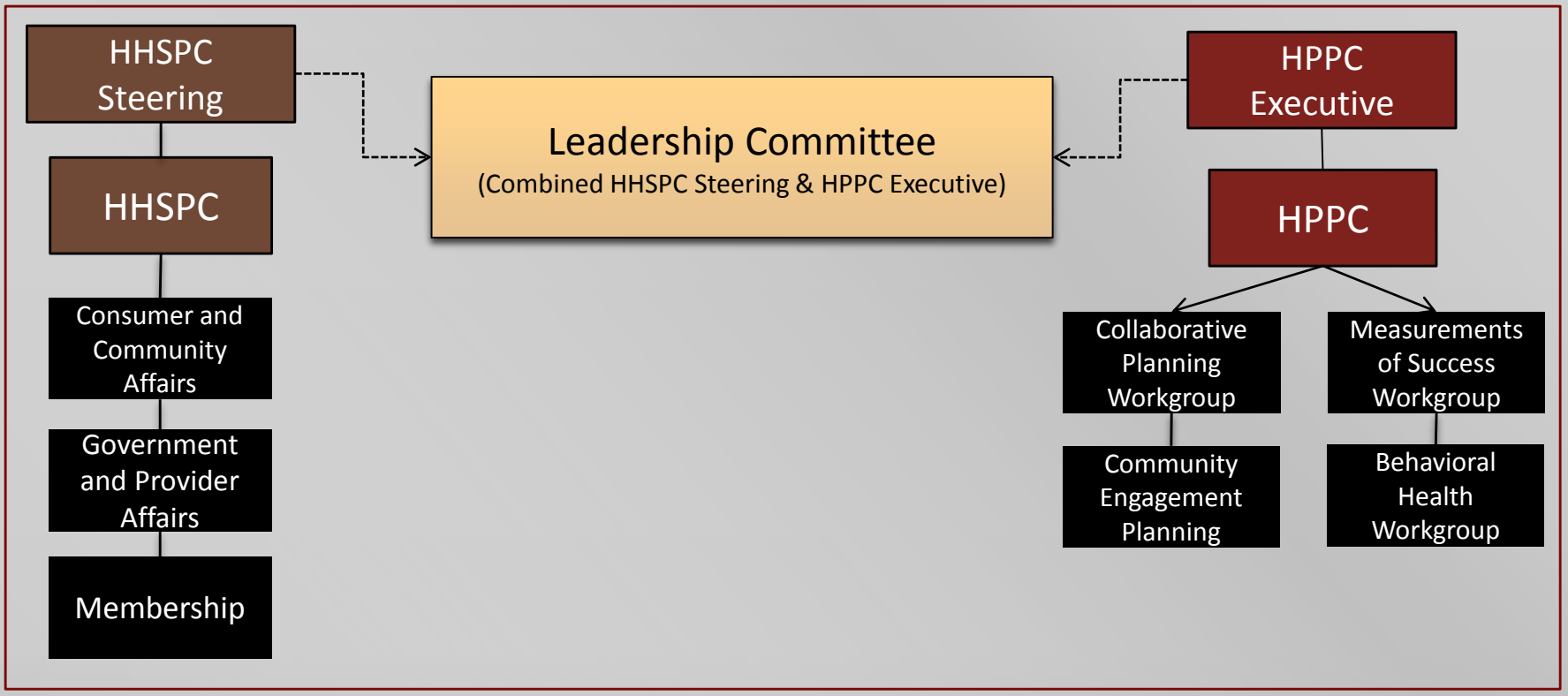
Model 2
Shared Leadership

Pre-Transition Period (October/November 2013)

- Vote on model by HPPC and HHSPC
- Adoption of Shared Leadership Collaborative Planning Model
- Amend by-laws of both councils to create Leadership Committee

Full Implementation (January 2014)

- Leadership Committee is formed.
- Meeting structure and content is determined.



Evaluation and Next Steps (January 2015)

- Evaluation of first year is completed and results presented to both councils
- Vote on whether to pursue further collaboration or remain operating with Shared Leadership Collaborative Model

Vision/Mission	Guiding Principles
To ensure a continuum of HIV services for community members at risk for or living with HIV by increased collaboration	1. Consumers are better served by community-planning that is streamlined, effective, collaborative 2. Parity, Inclusion, Representation 3. Thoughtful and respectful management of change 4. Community speaking w/ multilingual voice

STRUCTURE
Monthly meeting dedicated to collaborative activities – shared responsibility for deliverables
Leadership Committee attends both council meetings
Balance in voting between HHSPC and HPPC Committee members
Leadership Committee charged with generating/ discussing collaborative activities
Staffing remains the same with increased collaboration between HHSPC staff and DPH prevention staff
Administrative mechanism remains the same
Shared responsibilities for deliverables

Strengths and Weaknesses

Strengths:

- Least amount of disruption
- Membership for both councils does not change
- Maintains the different cultures and goals of both councils
- Strengthens collaboration while leaving door open to further collaborate or not

Weaknesses:

- Voting challenges due to the differences in HPPC & HHSPC policies
- Doesn't go further to address differences between councils
- Does not achieve any of the benefits or strengths of the integrated model.
- Maintains the status quo.
- Does not keep pace with the national movement towards full integration of care and prevention

Challenges

Technical:

- Leadership Committee: time, voting, representation, scheduling
- Changes to by-laws

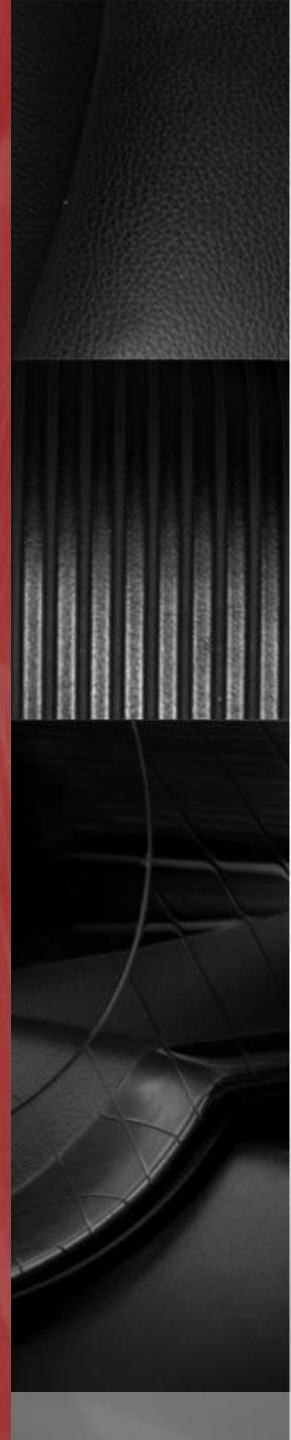
Adaptive:

- Blending two different processes and cultural histories in the merging of the HHSPC and HPPC Executive Committees
- Negotiating priorities of the two executive committees into one, coherent vision for the two separate councils

Motion

Recommend to adopt Model 1 – Time Phased Full Integration

Questions?



CPW – Members

HIV Prevention Planning Council (HPPC)

Laura Thomas (CPW Co-Chair)

Richard Bargetto

Jackson Bowman

Ed Chitty

Jose Luis Guzman

Andrew Lopez

David Gonzalez

Tracey Packer – HPS Staff

Eileen Loughran – HPS Staff

HIV Health Services Planning Council (HHSPC)

Matthew Miller (CPW Co-Chair)

Ron Hernandez

Kenneth Hornby

Lee Jewell

Maritza Penagos

Charles Siron

Channing Wayne

Dean Goodwin – HHS Staff

Kevin Hutchcroft – HHS Staff

Mark Molnar – HHSPC Staff

Support Staff

Ali Cone – Shanti

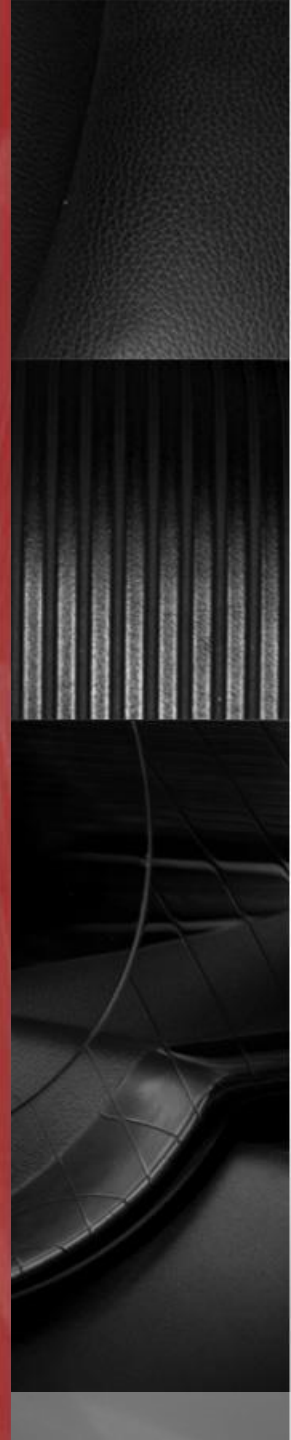
T. J. Lee - Shanti

Betty Chan Lew – HIV Prevention Section

Consultant

Michael DeMayo

Appendix



CPW – Structure and Operations

Mission: The CPW will operate as a joint work group between the HHSPC and HPPC. The mission of the work group is to ensure a continuum of HIV services for community members at risk for and living with HIV by planning increased collaboration between Councils.

Members : The CPW has two co-chairs with one representing the HPPC and one the HHSPC. The work group is comprised of the following members:

- 7 members from each Council (with 1 vote each).
- 2 HIV Health Services Section staff representatives (with 1 shared vote)
- 2 HIV Prevention Section staff representatives (with 1 shared vote)
- Director of the HHSPC as an additional non-voting member

Members of the HPPC and HHSPC who are not CPW members may attend meetings and participate in discussions but will not have voting privileges.

Meetings: Between March and September 2013, the CPW met seven times. Due to scheduling conflicts and other Council commitments, the CPW did not meet in July.

CPW – Goals and Objectives

Goal: To develop a model of collaboration that ensures the integrity and unique character of HIV planning in San Francisco.

- Objective 1: Convene a working group comprised of members of both the San Francisco HIV Health Services Planning Council (HHSPC) and HIV Prevention Planning Council (HPPC).
- Objective 2: Receive detailed presentations on the planning process and wider systems for both HIV prevention and care.
- Objective 3: Review the possible collaborative frameworks that have been implemented nationally.
- Objective 4: Outline a collaborative framework for San Francisco that incorporates all necessary elements to achieve the primary goal of providing services to those infected and affected by HIV.

CPW – Goals and Objectives

Goal: To develop a model of collaboration that ensures the integrity and unique character of HIV planning in San Francisco.

- Objective 5: Convene an all-day retreat focused on identifying the steps necessary to full implementation of the selected collaborative model.
- Objective 6: Prepare a presentation on the work of the CPW for a joint session of the HHSPC and HPPC.

CPW – Meeting Content

Meeting 1:

February 4th

- Election of CPW Co-Chairs: Laura Thomas and Matthew Miller
- Update from Healthcare Reform Task Force
- CPW member discussion: Perspectives on collaborative planning
- Review and modification of CPW mission and objectives

Meeting 2:

March 8th

- Overview of HPPC and HHSPC planning models
- Presentation of current collaboration models being implemented nationally

CPW – Meeting Content

Meeting 3:

April 12th

- A review of prevention and care systems, highlights from each councils planning documents: HPPC Jurisdictional Plan and HHSPC Comprehensive Plan
- Discussion: The priorities of each council and their shared goals from each members perspective

Meeting 4:

May 9th

- Summary of individual interviews conducted since the last meeting with each CPW member.
- Review of prevention and care federal and local mandates
- A detailed review of collaborative models developed by NASTAD
- Planning Group Exercise
- Collaborative model selection for further development at all-day retreat

CPW – Meeting Content

Meeting 5:

RETREAT

June 20th

- Small group exercise: Refining the 3 models selected at Meeting 4
- Presentation on final model revisions
- Selection of 1 model for recommendation to the joint council

Meeting 6:

August 8th

- Presentation of the three draft models:
  - *Strengths/ Weaknesses*
  - *Technical and Adaptive Challenges*
- Further revisions to selected models for joint council presentation

CPW – Meeting Content

Meeting 7:

September 18th

- Final review of the two models selected for presentation at joint council meeting
- Draft joint council presentation content

Collaborative Models

Collaborative Model	Description
Membership/ Cross-Representation	**Each group may have representatives from the other or share common members.** • Seats mandated through planning guidance. • Members from housing planning groups or other local or statewide planning bodies can be included in membership categories and is not just limited to care or prevention
Information	**Groups may share knowledge and data.** • Share presentations or data presented from outside sources • Share information related to a specific jurisdiction used in planning (epi data, resource inventories, etc.)
Specific Projects	**Collaboration around specific projects.** • These relationships can be formalized through Memoranda of Agreements • Joint workgroups or task forces composed of members from each council • Shared technical assistance can be requested

Collaborative Models

Collaborative Model	Description
Joint Meetings	Regular Meetings – confined to monthly meetings between co-chairs of each council Coordinated Meetings – The two planning bodies are separate entities but share meeting dates and locations Subcommittees or Task Forces – convened to address specific planning issues or coordinate joint efforts Special Forums –special forums that allow for each council to present specific information
Prevention/Care Subgroups	**Prevention and care are subgroups of a larger group.** • Involves creating an oversight body that directs or oversees the work of two separate, smaller councils that remain distinct
Merged Process/Full Integration	**A single group with a single set of bylaws may meet to plan for both prevention and care** • Full integration would require a very specific implementation plan with several groups tasked with solving various merged processes (bylaws, membership and council make-up, committee structure, etc.)

Care and Prevention Planning: Comparison of Current Models

Prevention Planning

- Ensure planning reflects the local epidemic
- HIV positive individuals are a priority population
- Jurisdictional HIV Prevention Plan
- Prioritize based on the local epidemic
- Foster linkages between the plan and the health department application
- Assess effectiveness of plan
- Evaluate the process

Care Planning

- Comprehensive plan for Ryan White funds
- Ensure planning reflects the local epidemic
- Assure involvement of HIV infected individuals
- Unaligned with any service provider in the process
- Determine allocation of funds
- Promote coordination and linkages of services
- Assess effectiveness of plan