

Jurisdictional Coordination of Integrated HIV Prevention and Patient Care Planning and Implementation

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Abstract

Jacksonville, Florida, provides services to persons living with the HIV. A federal call for integrated HIV prevention and treatment was published on June 19, 2015. This study unveils the principles that guided the local response to that call. Service providers have not systematically engaged in strategic planning for system improvement, the absence of which defines the boundaries and properties of the service system. Integration requires a unifying strategy as it draws leaders from their respective silos. Directed leadership, community-based participatory research, and action research provided a science-based framework for integration. Quantitatively, one-third of the planning implementation journey has elapsed, and 46% of the 75 planned activities have either reached fulfillment or are ongoing. Another one-fourth is in progress and slightly more than one-fourth (28%) are pending. Qualitatively, this study recorded 7 system-level changes. Progress to date is a harbinger of future system-level changes.

Keywords

HIV services integration, integration HIV prevention and treatment, CBPR and community planning, community planning and HIV services, working across silos

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Introduction

Integrated prevention and treatment is becoming state of the art in HIV health services.¹ The concept of integration in health services is not new,² but implementation of integrated HIV services in the Jacksonville Transitional Grant Area (JTGA) is.³ Therefore, Ryan White Parts are encouraged to work across their siloed funding sources, governance structures, and policies to close gaps in services and more comprehensively address the needs of clients within the jurisdiction. The development of creative partnerships, alliances, and cooperative agreements can engineer a new system that is more responsive to stakeholder's expectations, including clients.⁴ Foster-Fishman and Behrens define a system as an entity, consisting of interacting parts, that accomplishes specific functions. But unlike engineering systems, health and social systems are simultaneously multifaceted and dynamic, and their properties or attributes arise from exchanges and mutual dependence of diverse actors, performing activities defined by specific roles.⁵ For example, a test-and-treat approach to HIV prevention expands testing and accelerates early identification

of HIV status. But what good is that if the treatment side of services lack opportunities for rapid linkage to care, gaps in retention support services, and client attrition? The scenario described impedes viral suppression.⁶ There is an all-out attempt to stitch the seams of HIV community health services to stop the bleeding of less than perfect linkage and lost to care. To that end, Northeast Florida widely recognizes the value of services integration; nonetheless, ideas that seem sound require careful examination and planning. To unmask pertinent details of the local services integration

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What Do We Already Know about This Topic?

HIV prevention and treatment are interdependent, and strategies are needed for seamless linkage to care once people test positive for HIV and are ready to initiate treatment.

How Does Your Research Contribute to the Field?

This study informs the process of local stakeholder mobilization and engagement for changing the delivery of HIV health services at the community level.

What Are Your Research's Implications toward Theory, Practice, or Policy?

Local Ryan White prevention and treatment organizations need assistance navigating out of siloed operations to identify interconnections and relationships that support the development of more comprehensive solutions to ending the HIV epidemic.

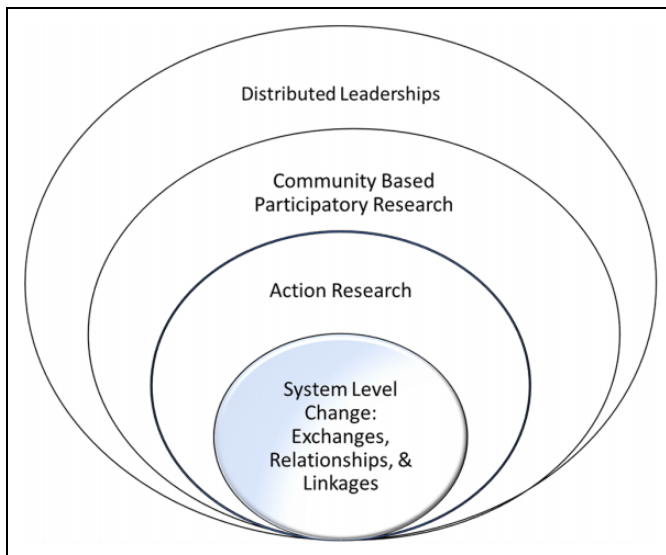


Figure 1. The cascade effect of 3 research models informing system-level planning for change.

planning, some of the original framers of the HIV prevention and treatment integration effort relied on 3 theoretical frameworks to organize the sociostructural change process as a dynamic enterprise. Figure 1 presents a union of 3 frameworks depicted as expanding circles of influence on planning for system change. Moving from the outside in, the distal influence of distributed leadership (DL), community-based participatory research (CBPR), and action research (AR) offer guidance for driving change.

Described here is a theoretically driven method of designing HIV health services integration. While a comprehensive review of DL, CBPR, and AR is beyond the scope of this study, brief definitions and explanations follow that show how the research principles of each framework guided the workgroup's management of the first-ever community-wide HIV prevention and treatment integration efforts that targeted system-level change (SLC). Distributed leadership (also known as shared or team leadership) informed interpersonal exchanges that arise from the actions (i.e., practices) of multiple leaders (i.e., people) in diverse situations (i.e., place or context). Spreading the leadership function over multiple people generates diverse interactions that bring ideas to the surface for system reconfiguration, improvement, and transformation. This multiplexity facilitates the exchange of ideas and insights in a multisectoral working environment, where it is a team, rather than an individual, that manages change. In other words, interactions arise from the intersection of people, place, and practice (PPP), each of which is reciprocally deterministic. That is each P element moderates and is moderated by the other.^{7,8} Community-based participatory research, on the other hand, is a partnership experience, involving cooperation between community members with and without research backgrounds. Key partnership principles included the use of community strengths and resources, nurturing co-learning, relying on community definition of real and perceived integration problems, and achieving long-term commitment by engaging in equal participation that converged in consensus.^{9,10} Finally, AR is a spontaneous and lively interactive process among participating stakeholders. It focuses on the development of applied solutions to address the characteristics and operation of situations that impact the lives of constituents. Hence, it adopts a democratic process of active, social engagement in decision-making to improve the experiences of individuals and communities.¹¹ It thrives on healthy interpersonal relationships, identification of shared priorities, carefully delimited needs, capacity to develop solution strategies, coupled with implementation and evaluation skills for informing course corrections. The practical application of these concepts involved recognition of multiple leaders, participants alternating between expert and learner roles depending on the conversation, giving deference without being obsequious, and critically evaluating ideas by robust question and answers without personal attacks. The principles extracted from the models were useful for cross-collaboration because they provided insights regarding how to approach participatory engagement, self-manage, promote buy-in and collegial allegiance, finesse consensus, and sustain commitment of workgroup members for planning change and implementation of planned activities.¹²

Service integration is the antithesis of fragmentation. What is fragmentation? Stange's editorial titled, *The Problem of Fragmentation and the Need for Integrative Solutions*, described a fragmented health-care system as one that delivers commodities, not relationships; focuses on parts without a sense of the evolving whole; expands revenue without increasing efficiency; and places more emphasis on the disease a person has than on the person who has a disease.¹³ A medley

of funded, ancillary services aims to improve fragmentation in HIV care and services, but the service mix does not address the underlying problem or problems. Lasker and Weiss outline reasons for the continuation of fragmentation in health services.¹⁴(pp. 15,18,30,32)

... Many of the [complex] problems that affect the health and well-being of people in communities... cannot be solved by any person, organization, or sector working alone... Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of [community health] problems and develop effective and locally feasible solutions to address them. [But], the success of any community collaboration depends on the way it is run... [Therefore], the leadership of a collaboration fosters a meaningful and productive group process by creating an environment that values listening as well as speaking, honors, and respects different kinds of knowledge and points of view, promotes the development of a jargon-free language, makes participants feel comfortable expressing their ideas, and combines what different people know.

In the JTGA, the moment is right for connecting the expertise of different people for HIV services integration. Duval county, Florida, is on the list of "... 48 counties... in the United States... with the highest number of new HIV diagnoses..." p. 1¹⁵ An urgency exists to fortify HIV prevention and treatment.

HIV health services integration is not a quick fix. Addressing fragmentation in HIV prevention and treatment by examining discrete components of the problem in isolation is limiting because it ignores the intricacies among components.¹⁶ Doing so is considered a reductionist approach, which has been successful in controlling infectious diseases¹⁷ but is less successful with chronic conditions¹⁸ and some reemerging infections.¹⁹ Thus, integration requires awareness of the web of causation, that is, the permutations of multiple factors interacting in different ways, and producing complexities^{20,21} that are not amenable to solutions generated by linear cause-effect thinking. For example, availability of effective, publicly funded, HIV medications and access to them seem simple enough to promote medication pickup and adherence. But these factors do not exist in isolation. Late diagnosis of HIV among groups such as injection drug users, delayed linkage to care, noncontinuous engagement in HIV care, and treatment cascade attrition worsens when barriers exceed facilitators of care engagement.^{10,22} Housing, homelessness, food insecurity, transportation, unemployment, underemployment, stigma, limited social support, inadequate screening tools for informing the development of tailored plans of care, among others, interact with factors previously mentioned to produce formidable obstacles to the equitable distribution of the benefits of antiretroviral therapy. Disparities in health outcomes occur when the most vulnerable persons living with HIV/AIDS (PLWHAs) are involved.

Teams working on HIV prevention and treatment integration require eclecticism. Therefore, it takes understanding

constellations of individual risk factors and how their accumulation creates a chaotic state, what some call a syndemic, that results in excess burden of disease among affected groups. It also requires change agents to recognize that solutions, which are comprehensive in scope, not only have a more significant potential for problem-solving but is even beyond the capacities of single individuals, institutions, or professions to develop.²³ Research using stratification analyses from a US and Canadian multisite collaborative of adults with HIV, aged 18 years and older, highlighted the imperative of a wide-ranging focus for integrated HIV prevention and treatment services. In the cohort, "the older the individual, the greater the probability of viral suppression (HIV-1 RNA \leq 200 copies/mL) in both the retained and not retained in care groups."²⁴ Whereas viral suppression was about 42% for the in-care 18 to 29 years age-group, it was 58% for 40- to 49-year-olds and 61% for 50- to 59-year-olds. Viral suppression was age graded. Considering the multiplicative effect of risk factors, and their differential impact on viral suppression, local strategies aimed at mitigating the medley of barriers to care. Therefore, targets of change included vulnerable PLWHAs, challenges that interrupt involvement in care, tailoring care plans to address obstacles to care engagement, and creating a fast-track linkage/relinkage to HIV care protocol for clients with complex care management needs.

System thinking is key to integrated HIV prevention and treatment. A system implies inputs, mediators, outputs/outcomes, and feedback.²⁵ Persons living with HIV/AIDS; the staff of funded services providers; funding sources; and local, state, and federal agencies along with their policies, procedures, and practices, including regulatory bodies, are on the input side. Activities such as outreach, counseling and testing, partner identification, scheduling, linkage, relinkage, care engagement and retention, adherence counseling, medication management, services targeting barriers mitigation, referrals, follow-ups, and so on, comprise mediators—mediational influences. Testing for HIV, accepting posttest advisement, keeping HIV-related appointments, picking-up medications, adhering to medication regimens, and achieving viral suppression or an undetectable viral load are examples of system outputs and outcomes. Completing satisfaction and needs assessment surveys, submitting grievances orally or in writing, participating on funded provider's Consumer Advisory Boards, and participating on HIV Health Services Planning Council or associated committees are examples of feedback. These system elements arrange into people, organizations, materials, and procedures (also known as POMP). The arrangement of POMP and the ensuing interactions produce relationships, linkages, functions, and exchanges. From a system thinking perspective, SLC is the deliberate process of modifying the present circumstances so that both structural and relational underpinnings of health services operations become more rather than less seamless.²⁶

System redesign is essential for services sustainability and relevance. In a systems typology, outcomes in the short-term are synergistic. That is, they are the result of the multiplicative effect of POMP. But over the long term, entropy—a decline in outputs—occurs unless a surge or reorganization or

reengineering of inputs follow.²⁷ Northeast Florida public health, health services, and social services leaders have accepted integrated HIV prevention and treatment as a paradigm shift for addressing entropy. In summer 2016, the JTGA formed a steering committee of 6 members. Members leveraged the existing resources of funded and unfunded HIV health services providers, including local university faculty, and created the Integrated HIV Prevention and Patient Care Plan (IHPPCP) workgroup. The group's lifecycle is January 2017 to December 2021. The IHPPCP workgroup operates as a committee of JTGA HIV Health Services Planning Council. The purpose of this article is to unveil principles derived from three frameworks and show how those principles guided the interactions of the IHPPCP workgroup. Specific aims were to create a social environment conducive to collaboration that served as an incubator for navigating the transition from abstract idea (integration) to a selection of practical change strategies accompanied by implementation activities. Submission of this work in the public domain invites dialogue and critique about the integrity, worthiness, and limitations of one local effort to satisfy a federal policy initiative for improving the jurisdiction's system of HIV care and services for the benefit of PLWHAs.

Materials and Methods

Recruitment and Group Identification

A steering committee used snowball sampling (each person recruits someone else) to grow its membership from 5 to 18, over 45 days. At saturation, core sectors of local HIV prevention and treatment stakeholders had representation from entities such as the HIV Health Services Planning Council, all Northeast Florida Ryan White Parts, First Coast Community AIDS Prevention Partnership (FCCAPP), funded and unfunded HIV health and social services organizations, and persons living with HIV. There was indirect representation of the criminal justice system on the workgroup. Multiple (at least 5) Ryan White staff provided medical care, case management, HIV testing, and pharmaceutical assistance to the currently incarcerated. The group adopted the name, "The JTGA Integrated HIV Prevention and Patient Care Plan (IHPPCP)" workgroup and met almost monthly. By June 2016, the workgroup completed its written plan. The last 6 months of 2016, which included grant writing for submission of the annual Part A grant application, was used to organize resources for implementation of the plan. The formal kickoff of implementation began in January 2017. The group met 3 times during calendar year 2017—January 11, 2017, April 12, 2017, and July 12, 2017, and 5 times during calendar year 2018—January 10, 2018, March 1, 2018, June 13, 2018, September 12, 2018, and December 12, 2018. Group meetings lasted 2 hours. Annexation of the word, workgroup, after IHPPCP was a subtle signal to communicate to members the normative expectation of active involvement. So far, giving the workgroup a title created an identity, but title language alone, although imperative for

social identification, was superficial in the absence of processes to guide group work.

Systems Philosophy

The JTGA has a network-centric systems approach to HIV prevention and treatment. That means the jurisdiction "...encourages relationship-building among and between individuals and organizations across traditional disciplines and fields to achieve relevant [National HIV/AIDS Strategy goals, (NHAS) reduce new HIV infections, increase access to care and improve health outcomes for PLWHAs, and reduce HIV-related disparities and health inequities]. . . ." Transdisciplinary (more than one branch of knowledge)²⁸ interactions to problem conceptualization and analysis, brainstorming, data needs definition, collection, analysis, synthesis, and interpretation broaden understanding of the complexity and determinants of the HIV service structure and functioning. A systems philosophy is apropos because SLC is a complex process. It involves inherent, self-regulating, and self-organizing interdependencies that are always in flux, moderated by feedback, and have nonlinear effects that can be unstable at points of expression. The underlying determinants of SLC include relationships, linkages, and exchanges, which are characterized by dynamic interactions among the trio, each of which responds to and influences the multiplicative connectivity between them. In view of the JTGA's system approach to HIV prevention and treatment, the principles of DL, CBPR, and AR—exploring, facilitating, empowering, involving, reflecting, evaluating, co-learning, and communicating—offer leverage points, in a cross-sectoral collaborative environment, for altering exchanges, relationships, and interactions around which HIV service delivery structure and functions coalesce.²⁹

Tool Kit

A series of actions served as a tool kit for assessment of the HIV health system service gaps and for guiding the workgroup's processes. To date, 11 specific procedures have helped the workgroup navigate toward its intended destination—integrated HIV prevention and patient care services.

- o Transitioned the stages of group development (from devotees to cohesive unit)
- i. An example follows. When the workgroup came together (forming step), the convening leader focused on orientation and boarding—a brief discussion of who we are, why we are here, and what we want to do. But new groups also pass through a storming stage. Disagreements over methods and what things mean required spending time on those issues to achieve resolution. The performing (productivity) phase occurred after members had reached consensus on what was realistic to accomplish and codified it in a written plan.

- Recognized the diversity of interests and agendas of group members (active listening)
 - i. An example follows. Workgroup interaction was passionate, but not defensive, sarcastic, and authoritarian, which resulted in inclusion of different points of view in the selection of change strategies.
- Informed the workgroup's strategic planning process by identifying system barriers, gaps, and functional limitations (data for decision-making)
 - i. An example follows. The workgroup used three formative questions, which asked, "Where are we now? Where do we want to be in the future? How do we get there?" These questions uncovered issues such as the need for evidence-based interventions and HIV testing policies and procedures manual, data sharing, identification of groups at risk for adverse health outcomes, health disparities, social determinants of health, health literacy, allocation of resources, among others, identified in Tables 1 to 3. Subsequent alignment of these barriers with the National HIV/AIDS Strategy goals—reduce new HIV infections, increase access to care and improve health outcomes for PLWHAs, and reduce HIV-related disparities and health inequities—facilitated the selection of activities to mitigate the service system's barriers, gaps, and functional limitations.
- Created synergy (by initiating/extending dialog from points of common understanding)
 - i. An example follows. The workgroup discussed data and information relevant to barriers to care, identified potential solutions, and selected an option, by following the reasoning from interactions that produced clarity as discussions progressed.
- Developed momentum (by quickly focusing on mutual and achievable priorities)
 - i. An example follows. Upon identification of strategies to address barriers to care, group members self-organized into smaller groups for identifying tasks related to the policy and for development of an action plan to support implementation.
- Promoted a climate of civic engagement (by avoiding excessive criticisms of differences upon which members shared widely divergent views)
 - i. An example follows. Regarding how the jurisdiction should address HIV-related disparities, group members worked together in their smaller groups despite differences of opinions, while maintaining an openness to examine the merits of different viewpoints.
- Established an action plan for document planning, writing, reviewing, and updating
 - i. An example follows. The workgroup left nothing to chance. They created a table with column headers that identified critical steps in the production of the living document we called the IHPPCP. Phases of the document developmental process appeared in the rows of the table. This matrix incentivized accountability among stakeholders because each meeting prompted review.
- Managed disagreements (by disclosing assumptions and treating people with different viewpoints as equally vested in the community's health)
 - i. An example follows. Workgroup members were uninhibited in the expression of different ideas. Typical listeners' feedback was, "I never thought about it that way." These interactions facilitated examination of unique perspectives without tearing down relationships or creating a climate of us versus them within the group.
- Advanced an IHPPCP implementation protocol (calendar of meetings, documentation database, subgroups, task analysis, and reporting mechanisms) to transition from a written plan to acting on ideas
 - i. An example follows. The protocol provided a permanent record that informed group members about who does what, when, how, and how often. It also served as a baseline for adjusting expectations when activities fell behind schedule.
- Instituted staff support as a focal point of data warehousing, communications, recruitment of new members, and help desk for navigating operations and promoting transparency in group work
 - i. An example follows. The elapsed time between scheduled meetings generated work products, which required activities such as collecting, organizing, filing, summarizing, and reporting. Someone had the function as a central hub to ensure information flowed in a timely and efficient manner between sources and receivers for documenting linkages between planning and implementation.
- Empowered liaisons to work between the existing prevention and patient care planning bodies, so information about planning and implementation processes cross boundaries (cross-link)
 - i. An example follows. The workgroup identified volunteers who participated in cross-linkage. In other words, prevention and patient care, which still meets separately, have fair representation on both entities to ensure information exchanges and expansion of relationship nodes in the integrated workgroup context.

Communications

Principles derived from DL, CBPR, and AR guided the workgroup's engagement strategies. A collective understanding of what the future Jacksonville prevention and treatment services environment should become emerged as many statements of the status quo and many vision statements became public knowledge. Iterative dialog vetted the pros and cons of the laundry list of choices until a narrow list of options emerged. Then stakeholders leveraged interrelationships among themselves to assemble workgroups for managing planning

Table I. Jacksonville Transitional Grant Area Integrated Comprehensive Plan National HIV Strategy Goal 1 Implementation Monitoring, January 2017 to August 2018.

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies		Activities Associated with Strategies for Reaching Objectives	Task Status
I	Reduce new HIV infections	Increase the number of health-care providers offering routine HIV testing	1.1	1.1.1	Assemble a list of potential routine HIV testing health-care providers	Completed
			1.1	1.1.1	Assemble and distribute routine HIV testing policies and procedures manual	Completed
			1.1	1.1.2	Implement follow-up site visits with funded HIV prevention partners	Completed
		Increase the number of HIV testing events in Northeast Florida outside Duval county	1.2	1.2.1	Assemble a list of existing HIV tests sites in Northeast Florida (NEFL)	Completed
			1.2	1.2.1	Assemble a list of potential HIV test sites in Northeast Florida	In progress
			1.2	1.2.1	Support HIV testing events in Northeast Florida	Completed and ongoing
			1.2	1.2.2	Develop plan to identify potential HIV testing agencies outside Duval county	In progress
			1.2	1.2.2	Initiate high-impact prevention contracts with eligible HIV testing agencies	Completed
			Integrate social marketing into HIV prevention and treatment messaging	1.3	1.3.1	Develop youth-centric HIV prevention and treatment adherence messages
		1.3		1.3.1	Pilot test youth-centric HIV prevention and treatment adherence messages	Completed
		1.3		1.3.2	Select potent youth-centric HIV prevention and treatment adherence messages	In progress
		1.3		1.3.2	Give youth-centric HIV prevention and treatment messages to funded providers	Future
		1.3		1.3.2	Share social marketing techniques with HIV prevention and treatment providers	Future
		Each year during 2017 to 2021, add one or more PrEP/nPEP providers	1.4	1.4.1	Develop a local version of the statewide PrEP/nPEP plan	In progress
			1.4	1.4.2	Distribute CDC and FDOH-Duval PrEP/nPEP guidance to health-care providers	In progress
			1.4	1.4.3	Conduct PrEP/nPEP follow-ups during routine HIV surveillance site visits	In progress
		Each year during 2017 to 2021, add 5 nontraditional condom distribution centers in NEFL	1.5	1.5.1	Create a map of existing and potential condom distribution agencies in NEFL	Completed
			1.5	1.5.1	Share NEFL condom distribution map with FCCAPP	Completed
			1.5	1.5.2	Provide capacity building training to potential condom distributors	Completed
		Each year during 2017 to 2021, do one evidence-based intervention in NEFL	1.6	1.6.1	Conduct an evidence-based interventions gap analysis	In progress
			1.6	1.6.2	Develop an inventory of evidence-based intervention funding opportunities	Completed

(continued)

Table 1. (continued)

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies	Activities Associated with Strategies for Reaching Objectives	Task Status
			1.6 1.6.3	Create an inventory of local evidence-based intervention training resources	In progress
			1.6 1.6.3	Create an inventory of national evidence-based intervention training resources	In progress

Abbreviation: FDOH, Florida Department of Health, CDC, Centers for Disease Control and Prevention; PrEP, Pre-exposure prophylaxis; nPEP is non-occupational post-exposure prophylaxis; FCCAPP, First Coast Community AIDS Prevention Partnership.

Table 2. Jacksonville Transitional Grant Area Integrated Comprehensive Plan National HIV Strategy Goal 2 Implementation Monitoring, January 2017 to August 2018.

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies	Activities Associated with Strategies for Reaching Objectives	Task Status
2	Increase access to care and improve health outcomes for people living with HIV	Assess and mitigate barriers to HIV care engagement	2.1 2.1.1	Develop a barriers to care assessment tool (B2CAT)	Completed and ongoing
			2.1 2.1.1	Use the B2CAT to increase access to care	Completed and ongoing
			2.1 2.1.2	Use a strengths-based approach to engage clients in care	Completed and ongoing
			2.1 2.1.2	Client-clinician create a care journey map to support care engagement	Completed and ongoing
			2.1 2.1.3	Implement and share a client-centered approach (CCA) to service delivery	Completed and ongoing
			2.1 2.1.3	Share effective modalities of client encounters	Future/not started
			2.1 2.1.3	Evaluate and share client satisfaction with different care encounter modalities	Future/not started
			2.2 2.2.1	Develop early, prognostic indicators of imminent lost to care	Completed and ongoing
			2.2 2.2.1	Routinely review clients' CAREWare barriers profile	Completed and ongoing
			2.2 2.2.2	Address barriers to HIV care that create relinkage to care opportunities	Completed and ongoing
	2.2 2.2.2	Conduct barriers to care reduction case conferencing	Completed and ongoing		
	2.2 2.2.3	Create a standardized barriers to care reduction evaluation form	Completed		
	2.2 2.2.3	Evaluate and share client satisfaction with barriers to care reduction activities	Future/not started		
	2.3 2.3.1	Link HIV-positive pregnant and anticipated pregnant women to prenatal care	TOPWA referrals: HIV-positive women	Completed and ongoing	
	2.3 2.3.1		Identify and refer previously undiagnosed HIV-positive pregnant women to TOPWA	Completed and ongoing	
	2.3 2.3.2		Assess pregnancy expectations of HIV-positive WCBA	Completed and ongoing	
	2.3 2.3.2		Assess barriers to care engagement among HIV-positive WCBA	Completed and ongoing	

(continued)

Table 2. (continued)

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies		Activities Associated with Strategies for Reaching Objectives	Task Status
			2.3	2.3.3	Distribute TOPWA program materials to perinatal providers	Completed and ongoing
			2.3	2.3.3	Implement medication adherence and counseling among TOPWA clients	Completed and Ongoing
		Relink the formerly incarcerated to HIV ambulatory care	2.4	2.4.1	Implement a jail relinkage to HIV care demonstration project	In progress
			2.4	2.4.1	Evaluate the jail relinkage to HIV care demonstration project	Completed and ongoing
			2.4	2.4.1	Assess the sustainability of the jail relinkage to care demonstration project	Completed and Ongoing
			2.5	2.5.1	Review third-party fast-track linkage to care protocol	Completed and ongoing
		Develop a fast-track relinkage to HIV care protocol	2.5	2.5.1	Develop and implement fast-track linkage to care protocol in the JTGA	Completed and ongoing
			2.5	2.5.2	Assess the effectiveness of JTGA fast-track linkage to care protocol	In progress
		Expand the jail relinkage to care demonstration project in outlying counties	2.5	2.5.2	Share findings of JTGA fast-track linkage to care protocol	Future/not started
			2.6	2.6.1	Identify average time and staffing for reconnecting former inmates to HIV care	Future/not started
			2.6	2.6.1	Identify infrastructure needs for transitioning former inmates to HIV care	Future/not started
			2.6	2.6.2	Develop a jail relinkage to care manuscript	Completed
			2.6	2.6.2	Offer jail relinkage to care TA to interested stakeholders	In progress
			2.6	2.6.2	Distribute jail relinkage to care promotional materials	Future/not started

Abbreviation: JTGA, Jacksonville Transitional Grant Area; TOPWA, Targeted Outreach for Pregnant Women Act; WCBA, women of childbearing age; TA, technical assistance.

Table 3. Jacksonville Transitional Grant Area Integrated Comprehensive Plan National HIV Strategy Goal 3 Implementation Monitoring, January 2017 to August 2018.

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies		Activities Associated with Strategies for Reaching Objectives	Task Status
3	Reduce HIV-related disparities (differences in disease burden) and health inequities (preventable, unjust differences in health status)	Assess the nature and extent of HIV-related health disparities in NEFL	3.1	3.1.1	Create and disseminate a health disparities dashboard from clients' perspectives	In progress
			3.1	3.1.1	Create and disseminate a health disparities dashboard from providers' perspectives	In progress
			3.1	3.1.1	Identify trends in HIV-related health disparities and strategies to address them	In progress
		3.2	3.2.1	Develop health literacy assessment tools and promote use in Ryan White services	In progress	
		3.2	3.2.1	Develop at least two strategies for providing client-centered care and services	Future	

(continued)

Table 3. (continued)

NHAS Goal	NHAS Goal Definition	Objectives Fragments	Strategies	Activities Associated with Strategies for Reaching Objectives	Task Status
				Use health literacy assessments as a strategy to involve clients in the care process	
			3.2 3.2.1	Develop staff trainings to address the social, cultural, and linguistic needs of clients	Future
			3.2 3.2.2	Promote best practices for enhancing clients' self-esteem and self-worth	Future
			3.2 3.2.2	Provide client-centered confidence building training to Ryan White service providers	Future
			3.2 3.3.2	Providers document use of care and service strategies that target clients' self-worth	Future
			3.2 3.2.3	Identify service providers' cultural and linguistic skills for serving their clients	Future
			3.2 3.2.3	Develop cultural and linguistic competency (CLC) trainings for public presentations	Future
			3.2 3.2.3	Make CLC trainings available to providers and clients in multiple delivery formats	Future
		Increase access to nutritious food among HIV-positive individuals with food insecurity issues	3.3 3.3.1	Develop and pilot test a nutritional status food insecurity screening tool	Completed
			3.3 3.3.1	Use the nutritional status food insecurity screening tool in the client care process	Completed and ongoing
			3.3 3.3.2	Identify barriers to closing food insecurity gaps among HIV-positive individuals receiving care	In progress
			3.3 3.3.2	Stock Ryan White food pantries to address clients nutritional and food insecurity needs	In progress
		Implement a comprehensive media campaign to address stigma and discrimination	3.4 3.4.1	Assemble a care coalition to catalog treatment of NEFL PLWHAs in marginalized groups	In progress
			3.4 3.4.1	Identify collaborators for a storyboard about treatment of NEFL PLWHAs in marginalized groups	Future
			3.4 3.4.2	Develop a plan to recruit opinion leaders for educating city leaders about HIV health disparities	Future
			3.4 3.4.2	Develop tailored health advocacy messages for communicating with diverse local leaders	Future
			3.4 3.4.2	Develop a health advocacy communication calendar for implementation in Northeast Florida	Future

Abbreviation: persons living with HIV/AIDS; NEFL, Northeast Florida; NHAS, National HIV/AIDS Strategy.

activities. Subsequently, members reported to the full group during scheduled meetings. The large group meetings provided opportunities for probing, clarifying, challenging, rethinking, and resolving matters that frustrated the smaller subgroups. Because the jurisdiction has a history of working together on activities such as the Florida Department of Health triennial Client Needs Assessment Survey, a fluid environment quickly emerged for teamwork.

Planning Aid

Several planning tools help focused the workgroup. The most frequently used devices were action agendas, meeting minutes, planning matrices, Gantt chart, checklists, and surveys. A brief description of each follows.

- Agendas provided an outline for discussion during scheduled meetings.
- Minutes created a permanent record of meetings for accountability.
- Planning matrices (n rows by m columns tables) encapsulated goals, objectives, expected outputs, activities, timelines, and persons responsible.
- Gantt (horizontal bar) charts showing time on the x-axis and activities on the y-axis presented a visual depiction of lead and lag among planned events.
- Checklist enumerated things to be accomplished by a deadline.
- Surveys comprised both closed- and open-ended questionnaires that elicited data from respondents.

Information Elicitation Strategies

Focused questions provided the sounding board for data analyses, which aim to fill information gaps. The workgroup subcommittees reviewed qualitative and quantitative data. Data on the HIV/AIDS epidemiology, Youth Risk Behavior Survey, Statewide Needs Assessment, local needs assessment, lost to care (client attrition), counseling and testing, and Ryan White HIV/AIDS Service Reports, demographic reports, clinical performance measures reports, and HIV continuum of care reports were quantitative. In contrast, data from focus groups, interviews, public hearings, anecdotal stories, grant applications, and client advocates were mostly qualitative. One publication titled *UF Health Community Needs Assessment*³⁰ provided data that fit both categories. Information extracted from grant applications were secondary data because the original purpose of the data was different from its subsequent usage. These data generated discussions, which provided fertile ground for additional questions, additional research, development of insights, and brainstorming solutions to address existing challenges. The workgroup achieved consensus through praxis—an iterative process of data generation, analysis, evaluation, broad discussions, brainstorming, narrow-focused discussions, questioning, rebuttals, and consensus development.

Allocation of Responsibilities

The workgroup strategy designed and prioritized resources according to the NHAS goals. This approach secured cooperation based on inherent strengths and resources of the community. For example, FCCAPP, the jurisdiction's premier HIV prevention community planning group, took the lead on discussions and group activities aimed at reducing new HIV infections. Similarly, client health-care and social services providers stepped up for leading talks and generating activities aimed at increasing access to care and improving health outcomes. Prevention, treatment, and others jointly focused on brainstorming and selecting events for reducing HIV-related disparities and health inequities. By sharing leadership resources in a collaborative, decision-making environment, each stakeholder had opportunities for advocating various perspectives, disseminating information, supporting group learning, and developing communication self-efficacy to acquire loyalty to the HIV health services integration and implementation processes.

Sustainability of Collaboration

The workgroup continues to meet under new leadership. Membership comprises mostly new volunteers who have replaced participants lost to involvement by retirement and job relocations out of area. Current activities of the group include a review of the concurrence between the local cross-sectoral HIV prevention and treatment plan and the state of Florida HIV prevention and treatment plan. NHAS goal three emphasis on disparities mitigation also occupies the attention of the group. As of May 2019, a survey data collection plan is under review for comment. This plan will implement the *Client Self-Worth and Confidence Survey* and funded providers' *Cultural and Linguistic Competency Survey* during summer 2019.

Ethical Approval and Informed Consent

This study, conducted under the auspices of the JTGA, Ryan White Part A Planning Council (PC), waived the need for ethics approval and informed consent. Reasons follow: (1) the PC rejected informed consent because the study did not constitute research; (2) self-directed, collaborative community planning does not rely on ethics approval; (3) this planning process did not present a threat to the welfare of humans or animals; moreover, it sought to improve the well-being of humans; (4) The IHPPCP workgroup is a PC workgroup; (5) monitoring of the IHPPCP planning processes preserves a historical record of activities for transparency and evaluation; (6) IHPPCP self-selected workgroup members consent to "Florida Statute 119.01—state, county, and municipal records are open for personal inspection"³¹; and (7) IHPPCP group members acceptance of the statute would be unlikely to object to publication because they acknowledge that public interests in advancing the emerging science of system-level, HIV prevention and treatment outweigh possible harms of anonymized reporting of process and outputs.

Results

The goal-objectives-activities framework, presented in Tables 1 to 3, summarize accomplishments. National HIV/AIDS Strategy goals are federally mandated. The JTGA then specified objectives and defined related activities. Monitoring activities used the rubric: *completed* (actions that began in the past and achieved intended results), *completed and ongoing* (efforts that started in the past, delivered results at a single point in time, but require visitation at a future date), *in progress* (actions that began in the past and have not yielded intended results), *future* (action that have not been started), and *past due* (actions that are behind schedule). Tables 1 to 3 give details about each objective and associated activities developed by the IHPPCP.

Table 1 presents JTGA Comprehensive Plan National HIV/AIDS Strategy goal one implementation monitoring, January 2017 to August 2018. The aim of goal one is to reduce new HIV infections. Stakeholders identified 23 activities to accomplish six objectives focused on increasing routine HIV testing providers and number of testing events; using social marketing for messaging the target audience; rollout of new HIV prevention (pre-exposure prophylaxis) and treatment (non-occupational post-exposure prophylaxis) strategies; addition of nontraditional condom distribution centers; and use of evidence-based interventions. In this grouping, the status of activities is as follows: 43.48% completed, 8.70% completed and ongoing, 39.13% in progress, and 8.70% are future targets.

Table 2 presents the JTGA Comprehensive Plan National HIV/AIDS Strategy goal two implementation monitoring, January 2017 to August 2018. The aim of goal two is to increase access to care and improve health outcomes for people living with HIV. Stakeholders identified 31 activities to accomplish six objectives focused on barriers to HIV care engagement, individualized service plans, linkage of HIV-positive women to prenatal care, relinkage of formerly detained or incarcerated HIV-positive people to treatment, establishing a fast-track relinkage to HIV care provider protocol, and expansion of the correctional relinkage to HIV care program beyond Duval county. In this grouping, the status of activities is as follows: 6.45% completed, 61.29% completed and ongoing, 9.68% in progress, and 22.58% are future targets.

Table 3 presents JTGA Comprehensive Plan National HIV/AIDS Strategy goal three implementation monitoring, January 2017 to August 2018. The aim of goal three is to reduce HIV-related disparities and health inequities. Stakeholders identified 21 activities to accomplish four objectives focused on the assessment of health disparities, provision of client-centered care and services, mitigation of food insecurity through access to nutritious food, and comprehensive media campaigns to address stigma and discrimination. In this grouping, the status of activities is as follows: 4.76% completed, 4.76% completed and ongoing, 33.33% in progress, and 57.14% are future targets.

Figure 2 presents the status of JTGA Comprehensive Plan 75 activities and 16 objectives for three goals. The status of this

unfunded project activities is as follows: 17% completed, 29% completed and ongoing, 25% in progress, and 28% are future targets. The duration of the implementation plan is 60 months, and 20 months had elapsed from January 2017 through August 2018—the date when data collection was last updated. One-third of the time has passed, and almost one-half (46%) of all activities have either been completed or completed and ongoing, in addition to one-fourth, which are in progress. Slightly more than one-fourth (28%) are the focus of future attention. The encapsulated summary of Figure 2 shows the collective sense of ownership and commitment to HIV health systems improvement. Prevention has the least number of activities ($n = 2$), pending completion, followed by treatment ($n = 7$), and disparities inequities ($n = 12$). The JTGA has a lot to do to make progress on addressing disparities and inequities among PLWHAs.

Differential attrition presented a problem for the workgroup. Changing organizational priorities reduced workgroup participation of some collaborators more than others. Because the natural selection of subgroup members aligned people with similar and complementary expertise, when natural alliances paired people with joint institutional affiliation, group activities diminished when an institution reduced staff support or reassigned staff.

Discussion

The Current Look of Integration and Its Relationship to Strategies Adopted

In the two years (2017-2019) of the JTGA integrated HIV prevention and treatment experiment, the network has been strengthening relationships, interactions, and exchanges between stakeholders and service providers. This building process holds promise to create an unbridged system of HIV diagnosis, linkage, treatment, and retention in care. The work is ongoing; therefore, what the final form will look like is on the horizon, but not elusive. What currently exists is an emerging picture of the effect of change processes evidenced by seven fundamental system-level transformations. A description of each follows.

1. Realignment of monthly program manager meetings that target specific stakeholders with unique information. These meetings now assemble Ryan White-funded agencies' executive leadership responsible for organizational direction and business activities. Communicating directly with these leaders is key to getting agency resources and processes aligned with HIV prevention and treatment integration for changing the service delivery status quo.
2. Inclusion of FCCAPP as a functional member of the JTGA Parts AB Health Services Planning Council, which is responsible for assessing needs of PLWHAs, setting service priorities, allocating resources, and issuing service directives.³²
3. Institution of an annualized, Youth Outreach Back-to-School HIV Prevention Block Party hosted in August.

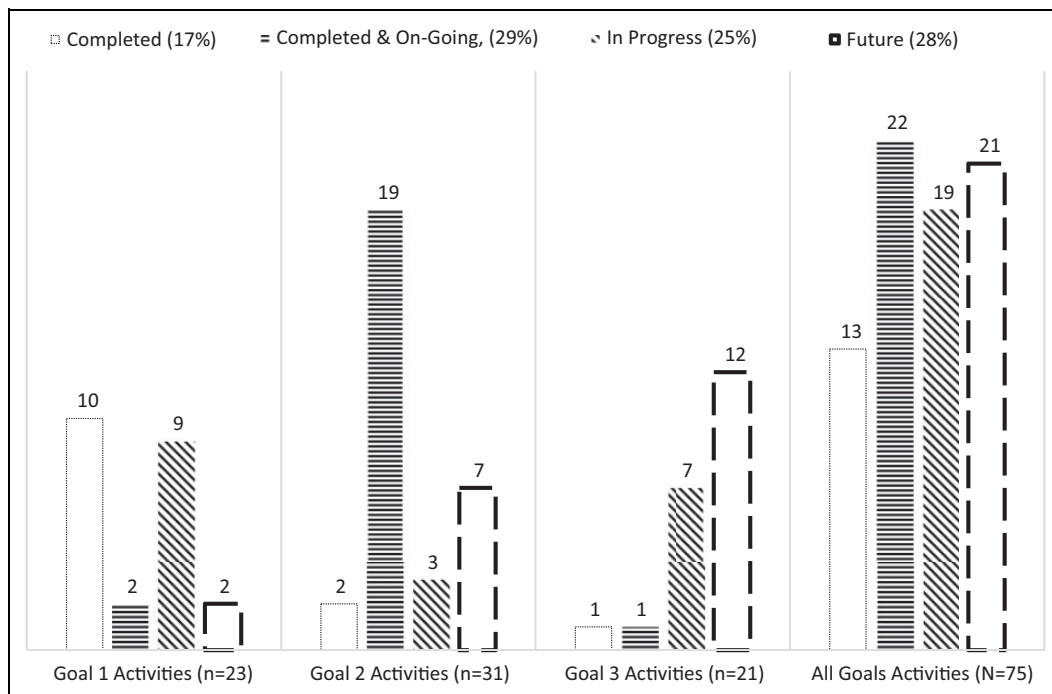


Figure 2. Status of JTGA comprehensive plan 75 activities and 16 objectives for 3 goals.

The event is in its third consecutive year of operation, and annual cost approaches \$10 000.00. In past years, 47 volunteers participated and attracted 189 residents, most (53%) of whom were in the targeted age range of 13 to 24 years old.

4. Development of a coalition—alliance for combined action—called Consortia Advocacy Program Relinking Inmates to Care Early. It still exists and has responsibility for connecting PLWHAs to HIV care and services upon release from incarceration or detention.
5. Development and implementation of multiple screening instruments for nutrition and food insecurity, health disparities, health literacy, barriers to care, legal support, substance use, and mental health, most of which are coded in the jurisdictions and electronic and social health record.
6. Implementation of colocation services agreements which grant office space and Internet access to collaborating partners for expanding access to services that are not native to a provider, thus minimizing burdens on clients attempting to access an array of services.
7. Initiation of dialog among local Ryan White Parts regarding a start date for kicking-off cross-sectoral quality improvement planning, implementation, evaluation, and feedback.

These signature SLCs have roots in trust-building. The direct evidence of trust came from how the workgroup engaged. Effective, verbal communications, not rushing to make decisions, neither censoring openness nor minimizing unpopular views were shared. Handling disagreements with gentility and publicly acknowledging errors, either of facts or reasoning,

evidenced a commitment among collaborators to avoid pettiness and to examine the jurisdictions' HIV health system status quo. Finally, participants acknowledged that the status quo is unacceptable, and this admission created ownership for the change that motivated the pursuit of system improvements.

Multiple reasons account for integration process realizing the seven specific SLCs. The list of reasons includes analytics, the presence of various leaders who are simultaneous learners, an atmosphere of engagement, deference without obsequiousness, and fostering innovation and creativity through empowerment—flexibility to pursue novelty without a priori details. The collaborative leadership approach, emphasized in DL, CBPR, and AR principles, nurtured an environment in which participants were soft on people but tough on issues. By simultaneously asking data-driven questions and expressing nonjudgmental disagreement, where indicated, preserved relationships and collegiality, which encouraged informative and insightful interactions. These strategies changed norms, practices, and relations because stakeholders

1. understood that the benefits of interdependence outweigh the costs of maintaining independence;
2. viewed the cross-sectoral collaboration as a whole that is greater than the sum of its parts;
3. perceived that the community is stronger together as a united group than as disparate, competitive agencies jostling for grant funding; and
4. acknowledged that the joint position statement by the Centers for Disease Control and Prevention and the Health Resources and Services Administration marked the beginning of a policy change "...to accelerate progress toward reaching the goals of the National

HIV/AIDS Strategy, which include preventing new HIV infections, increasing access to care, improving health outcomes, and reducing HIV-related health disparities.”^{33(p2)}

Strengths and Limitations

The strengths and weaknesses of this study are grounded in its theoretically driven methods: DL, CBPR, and AR. Collectively, the models that guided this study provided lenses for thinking about how to approach cross-sectoral collaboration and served as a catalyst for engagement and planning for change among participants who historically worked in the silos of their programs, constituencies, and health services priorities. The engagement process is a living demonstration of the democratization of knowledge.¹² From both supply and demand perspectives, the voices for change labored to overcome entropy by pointing forward to a state of more efficiency, less waste, and better quality of services. Stakeholders’ participatory involvement in planning for health services improvement and taking ownership of task implementation activities were clear strengths of this study.

Notwithstanding these strengths, this study has its limitations. The principles drawn from the models that informed the local approach to integration require considerable commitment to the idea that group members are credible change agents. They also need users to identify diversity and size requirements of group membership for balancing the complexity–productivity relationship that comes with aggregating people with different health services priorities, backgrounds, and personalities. Deviations from these principles can stymie synergies that the models offer. Thus, the approach described here may not work across all communities. Here is why. A team must have multiple leaders who are willing to share the leadership function. Diverse stakeholders must attend to issues that unify them rather than focus on their differences. Prioritizing in limited resources settings is less disconcerting where strong interpersonal relationships exist, and participants practice active listening. Where these facilitative conditions are absent, the potential for cross-sectoral collaboration diminishes. The JTGA context, culture, and actors may not be representative of what exists in every HIV health services system; therefore, the predictability of interactions, exchanges, and linkages may be erratic. Integration planners and implementers intending to replicate the use of DL, CBPR, and AR in their respective settings should tailor their approach to fit the context, culture, and actors. A December 13, 2018, Webinar titled, *Integrated Planning Activities for Prevention and Care: Best Practices and Lessons Learned*, acknowledged that “. . . a fully united or merged prevention and care planning body are not always feasible or the ideal approach to integrated planning for all jurisdictions. [Hence, the presenters recommended that] integrated planning activities should be developed with the unique considerations of the local community in mind.”³⁴

Dilemmas and Solutions

The workgroup addressed differential attrition in subgroups by heterogeneity. Diversification—varying the range—of people in subgroups to spread institutional representation more broadly over multiple subsets was the antidote to minimizing the impact of unplanned emergencies. Doing so made planning and implementation more rather than less stable and preserved a quorum of participants to staff the voluntary, community planning experience.

Key Learning

During the 22 months of IHPPCP implementation, completion of some activities did not always follow the planned time line or the initial conception of implementation or reporting. Three take-home messages emerged from working through anticipated setbacks: (1) *practical idealism*, (2) *karma—how you make your bed influence how you sleep*, and (3) *you are either at the table or on the menu*. A brief explanation follows. Flexibility is currency because adoption of a dogmatic attitude is antagonistic to collaboration and minimizes opportunities for making compromises, which are necessary to achieve consensus on value-based outcomes (practical idealism). Work diligently to create interactions that produce consequences that are desirable on the rebound. Interpersonal communication in decision-making contexts is more about the relationships than the transactions—the specific issue contemplated; therefore, resist the winner takes all mentality and create equity in exchange for what goes around comes around (karma). The third lesson learned is when working across silos expect to get only some of what one wants because one constituent has a partial influence on decision-making and outcomes (at the table). Because total control is incompatible with collaboration, partial control ensures that engaged participants do not experience domination by others (on the menu).

A systems approach to integration is incomplete without real-time learnings. For guiding SLC, the critical learning insights—making compromises, attending to relationships, and having bounded expectations, that is, satisfaction with partial attainments—are the 20% of effort that achieves 80% of results. The key learning is the catalyst for activating the principles of DL, CBPR, and AR to establish the necessary and sufficient conditions for collaborative work in a cross-sectoral environment. Together, they create a context for focusing limited but discernible agreement and coordination by multiple agencies with historically different agendas. Change meets resistance, and sustainable change occurs in increments; therefore, change agents are not discouraged by the absence of seismic shifts in desired results. Instead, they accept the painstaking process of laying the foundation of permanent improvements, one step at a time, and waiting until a critical mass takes effect, where many, small gains (achievements) aggregate to create opportunities for a turnaround of conditions and states that prompted change planning and tasks implementation.

Implications of Lessons Learned

Communities intending to replicate this work can build on this local attempt. Critical analysis or critical evaluation (CE/CA), is a value-added benefit in regional planning. A retrospective look suggests that our work had a missed opportunity by the lack of external CE/CA. Months of intense directed planning, motivation to achieve, and desire to maximize efforts by demonstrable and meaningful outputs can unintentionally nurture the groupthink phenomenon as teams approach the short-run eureka effect—a new sense of understanding that comes from prolonged engagement. It is usual for people to value insights that arise from contemplative and deliberative inquiry, only to have the meaning dissipate in the long run, causing subsequent questions that uncover dimensions of the enterprise hidden in plain view. That experience comes from being too vested in the outcome of planned change. A national, electronic, double-blind portal that allows for review and feedback can help jurisdictions maximize long-run benefits at short-run costs. In other words, local actors can leverage expertise from a broader community of likeminded people whose only interests is objectivity.

Future Directions

The JTGA has made consistent progress in the implementation of its IHPPCP. If the past 22 months are any indications of what the future holds, then the jurisdiction can look forward to accomplishing future activities if new members of the workgroup become embedded and vested in the updated objectives and strategies, which aim to fulfill the National HIV/AIDS Strategy goals that guided the local plan. Distributed leadership, CBPR, and AR helped to create the environment, which set clear expectations regarding the nature and purpose of the planning and implementation processes. Doing so minimized uncertainty about ends (future accomplishments) and means (method for achieving future accomplishments and reporting them). Research has affirmed the means–ends connection for productive public health collaborations to occur in a climate of civic engagement.¹⁴ One intangible, but integral property of the JTGA collaboration was affect-based trust. Indicators of trust were mutual respect and regard for each other's well-being through communications.³⁵ These norms produced attachments that added value to the interpersonal relationships forged during collaborative work; consequently, supportive relationships between group members created firm commitments to the IHPPCP activities. Although most of the original workgroup has changed, the change was normative; therefore, if the workgroup's culture remains intact, it should strengthen relationships among new members through December 2021.

Practice Implications

Paradigm shifts alter the behavioral status quo and create discomfort. These discomforts included having to publicly explain the rationale for programmatic decisions, practices, or

strategies that participants may have inherited; listening to unsolicited, oral feedback that lacked the benefit of review often associated with written communication; and enduring protracted discussions that for some participants seemed more academic than pragmatic. Fortunately, the professional preparation and maturity of workgroup members were such that emotional intelligence prevailed; good temperament remained the group norm, and emotional self-regulation provided the equivalent restraint against retaliation. These demonstrations provided evidence that ensuing discomforts of paradigm shifts need not traumatize communities engaged in SLC planning and implementation. Change management in public health and health services is central to maintaining service relevance and health system efficiencies. Cognitive and behavioral skills that support change management include service learning, shared leadership occurring in a climate of trust, and concomitant recognition that community health challenges are beyond the reach of single entities to address. Bringing together disparate parts of health systems to understand and elucidate the mechanisms of interconnections and interactions between the units hold promise to create sustainable integration. Health-care resources are constrained, but with creativity and innovation, learning communities can develop the competence to address problems through strategic and focused dialog, which is iterative, fluid in consistency, respectful in tone, and valued in orientation. These perspectives provide at least some of the necessary and sufficient conditions to achieve compromised consensus for creating synergy to develop and implement solution-focused plans for addressing gaps in the JTGA HIV health services system.

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