Stakeholder Input on Key Questions
In Preparation for the External Consultation on Program Collaboration and Service Integration (PCSI)

Introduction

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) has set Program Collaboration and Service Integration (PCSI) as a top priority activity. The operating definition of PCSI is defined as a mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services. The focus of PCSI is on integrated service delivery at the client level, or point of service delivery, and is not intended to imply integration at the organizational or structural level.

Over several years, barriers to program integration and recommendations to CDC have been cited in the literature. More recently, as a result of joint site visits to several jurisdictions conducted by the NCHHSTP Director and staff, additional barriers and recommendations regarding program integration have been identified. In brief, barriers have been cited in several categories and include:

- Restrictive and inflexible use of categorical funds
- Overly prescriptive program announcements and discordant program reporting requirements
- Burdensome and inefficient "administrivia"
- Lack of harmony, consistency, and synchronization of data collection instruments and surveillance systems
- Lack of integrated prevention guidelines
- Insufficient translation and integration of science and program
- Insufficient support, both technical and financial, for cross training, evaluation and dissemination of best practices

NCHHSTP's first actions toward promoting service delivery integration involve (1) developing a concept paper for review and comment by external partners, and (2) conducting a consultation with external partners to further receive further input in developing and refining the Center's action plan and next steps. This external consultation will be held August 21 and 22, 2007 in Atlanta, GA. The external consultation is organized around key questions in six domains that roughly correspond to the frequently cited barriers to service delivery integration. (See domains and key questions below).

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

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

Using the key questions within the six domains as a framework, four of the six organizations on the planning committee solicited input from their members in preparation for the external consultation. All the organizations asked the same questions, but used various mechanisms to gather the information (e.g., teleconferences, e-mail or written). NASTAD solicited input from AIDS Directors as well as state Hepatitis C Coordinators. Responses were obtained from 8 NASTAD, 3 UCHAPS, 17 NCSD, and 16 NTCA members. Organizational responses were merged by domain, and then all responses were categorized by common themes for each domain. Repetitive responses were condensed as were responses that identified a particular jurisdiction or that were highly specific to a single program.

The following represents the additional input received and is being shared prior to the external consultation with all those who will be attending as well as with the respective organizations on the planning committee for the external consultation.

Domain I: Vision/Level of Integration

1. Is there a minimum level or group of prevention services that should be available for every client seeking services in the US (e.g. a minimum prevention package)? If so what should comprise the minimum level of service?

No = 5 responses
Yes (unequivocal or qualified) = 39

Qualified Reponses

- Prevention services should not impede or deter screening or treatment and should not be offered routinely unless evidence to support effectiveness
- That would depend on age and geographical location of residence
- Decisions about integration/coordination should be made at the local level

Minimum Prevention Package Themes

Easy access to competent services for all

Every person in the US should have access to receive testing for HIV, TB, STDs, and viral hepatitis in accordance with the latest practice standards. All should be able to easily access competent prevention messages for all communicable diseases either in a simple one stop process or with easy referral to additional experts.

Integration of Testing Initiatives

All testing initiatives, whether it is in a public clinic or an outreach event that is targeting similar at risk populations should be integrated to offer a wide variety of testing, including HIV, syphilis, viral hepatitis, and tuberculosis. Vaccine for HAV, HBV, and HPV could be available. Referral systems should be in place for those infected or at risk to available prevention/intervention programs.

One-shop stopping for TB/STD/HIV/Hepatitis prevention services will benefit the client

Range in Minimum Prevention Services Identified

- PCSI should be specific for HIV, STD, TB, Hepatitis
- Ideal minimum - a comprehensive prevention/ screening package where all individuals are screened at a point of entry. Could help to operationalize screening as a norm and reduce stigma for each disease
- Prevention services should include HIV, other STDs, hepatitis A and B. Local epidemiology and risk assessment of individual should determine TB and Hep C services. Thus, a minimum package includes the ability to conduct this assessment at both the community or facility and individual level.
- Minimum to include three levels of public health prevention: 1) comprehensive client centered model (education, wellness obesity prevention, physical activity, cancer

prevention, liver, wellness, heart healthy, STD prevention, HIV prevention, hepatitis prevention, etc.) 2) delayed initiation of high risk behaviors, behavior modification 3) vaccination, screening, testing and early referral for HIV, STD, hepatitis, TB, diabetes, cardiac, tobacco, drug use, flu, etc.

2. What are appropriate immediate, short, and longer term goals for accomplishing CDC's vision for PCSI?

Identify Specific Resources for PCSI

- Meaningful and plentiful - in the sense that use is not restricted, and plentiful, such that funds adequately cover administrative and programmatic needs.

Set Example of PCSI at/from CDC

- Increased collaboration from the top on down. If we are going to be successful in improving collaboration at the client level, CDC, National organizations and state level program administration must be better able to communicate. There should be improved collaboration at the level of cooperative agreement objective setting
- Document integration at Federal level
- Increase communication and collaboration at the CDC level for program-specific initiatives that have a cross-cutting impact
- One grant application, budget, and NGA for all categorical programs; Managers responsible for multiple programs
- Merge prevention program requirements for investigation, education and outreach.
- Funding stream and program integration at the national level

Incentives or grants to states

- Provide planning grants directly to local jurisdictions to develop complementary program services.
- Fund Liaison positions
- Create a specific funding stream to encourage integrative practices
- Without some sort of funding/grant integration, the programs will continue to work mostly independent of each other
- Support joint program planning
- Demonstration projects

Assess Capacity

- State by state that determines true capacity to integrate (based on state infrastructure, program design, state/federal funding, etc.)
- Thorough assessment of Public Health systems in all jurisdictions to determine the feasibility of PCSI
- Priority should be gathering data to determine the scope of this issue to determine how poorly or how well States have done in ensuring comprehensive sexual health care.
- Order the capacity of state's to meet the PCSI components. Realistically will need to develop tiers for state's to achieve minimum levels of integration.

Staff Training

- Training of staff so that cross-trained in public health activities.
- Cross train PHAs (STD, TB, HIV, Hepatitis) and allow flexibility to work across programs
- Identify workforce skill and readiness to implement PCSI
- Comparability and compatibility in training and capacity development front line staff and supervisors is needed to facilitate integration.

Develop, disseminate, and promote effective integration program models

- Holistic, comprehensive, integrated care in variety of public health delivery systems (i.e. state run, local health-authority run, etc).
- Disseminate descriptions of model programs that integrate infectious disease and other reproductive health content, including provision of contraception into their programs.
- Support quality improvement models and funding to cost effective public health programs that are comprehensive, collaborative and integrative

Develop clear, concise and applicable guidance

- Identify key areas for improvement, prioritize and start working on them. Do not get distracted by long-term goals.
- Defining integration and specifically what that may entail at state and local health jurisdiction levels (based on what's already working).
- An overall goal should be established for all programs to have collaborative plans for short /medium and long term goals
- Clear statements of expectations and minimum levels of services. Barriers should be eliminated that are created by separate categorical funding.

Integrated program materials, provider education, integrated media campaign

- Ensure integration efforts in targeted settings such as jails and correctional settings, STD clinics, family planning clinics, tb clinics.
- Promote increased referrals and comprehensive care mechanisms
- Short term items could be simply items such as collaborative input into the formation of guidance such as HIV PCRS Guidelines, HIV CTR Services, etc.

Set goals for integration

- From assessments or survey
- Develop metrics for PCSI
- Ensure comparability in program standards and requirements across funding streams/programs (i.e., HIV, STD, TB and viral hepatitis) in terms of "core" program requirements, indicators of "success" and methods for evaluating programs
- A long term goal should be some level of funding integration between HIV, STD, TB and the Hepatitis Programs
- Develop common indicators for outcomes across groups. Integrate outcomes measures and processes for gaining data for those measures.
- Identify areas of collaboration and areas that may not need collaboration
- Develop a logic model that envelops the long term strategies from an outcome desired perspective. The Logic Model should short/intermediate levels. The notion of each phase needs a brief but clear evaluation strategy for each level.
- Develop process and outcome measures that are commensurate with the extensive program development needs of cross-funding, cross-discipline, and cross-agency integration.(Appropriate process measures would include relationship building process outcomes (i.e. #'s of objectives met at cross-agency collaborative meetings). The relationship building between agencies that perhaps have not even collaborated before must be considered, valued, monitored, and supported by grant mechanisms.
- Documented patient level results measured through sampling of client survey. Such as 90% of all patients seeking services for STD will be tested for HIV and provided a risk assessment for TB and Hepatitis.

Evaluation

- Ongoing evaluation of cost-effectiveness of these strategies, facilitate the use of categorical funding for other uses (i.e. Use of HIV funds for HCV screening, use of STD funding for HIV-related PCRS and other activities).

Integrate data management and tracking systems

Strengthen relationships with state programs and agencies that affect the work of state programs

3. What restrictions on use of federal funds should the Center strategically tackle that would better support service integration if they were removed?

- The first is the ability for us to cross categorical funding sources. Also related to this is the ability for CDC categorical programs to converse internally. Money is not the only issue but integration of both funding and staff resources at the CDC level.

- Allowing HIV prevention funds to be spent on viral hepatitis and STDs would greatly expand the efforts of the under funded programs. This would allow for viral hepatitis and STDs to be included in work specifications for grantees. Ultimately, viral hepatitis and STD prevention efforts result in HIV prevention as well.
- Hepatitis A and B vaccine, adequate support for STD screening and treatment, SEP's
- True service integration would ultimately mean removing barriers imposed by categorical funding, putting different services (i.e. HIV, STD, Hepatitis and TB) on similar cooperative grant schedules, and asking health departments to work collaboratively on cooperative grant proposals. Program reports should be based on shared collaborative objectives. CDC will also need to work with HRSA to ensure that Care and Treatment are fully integrated with these integration plans.
- Use of federal funds for syringe exchange.
- HIV funds, when available should be allowed to be used for hepatitis projects. Current restrictions make this difficult if not impossible. HIV funds cannot currently be used to purchase HAV or HBV vaccine, despite the recommendation for vaccination for HIV+ persons and the overlap of risk populations. Restriction of federal funds for syringe exchange programs should be eliminated or significantly modified as most of the new HCV cases are among IDU. In addition, influence over the restrictions set forth in grants such as the SAMHSA 5-year HIV/ Substance abuse/ and Hepatitis, where there are restrictions against vaccine purchase would be very useful in the success of those programs.
- Funding streams that separate HIV, STD, and viral hepatitis prevention is a double-edged sword. On the one hand these discrete funding mechanisms ensure funds are used locally to support prevention to the targeted diseases. Unfortunately, these logical funding streams are prohibitive of front-line program integration. Meaning, our local health jurisdictions must keep all funding separate regardless of integrated clinical endeavors. We are urging our local health departments to integrate viral hepatitis A/B vaccine, and C screening into STD, family planning, and HIV work. They find it quite cumbersome to parse out RN or health educator time on such integrated activities. Moreover, in some of the larger local health jurisdictions they are not integrating because their fiscal and service delivery infrastructure is not set up to integrate such services. Funding restrictions related to what seems like sole disease streams are prohibitive at this level.
- Programs should be able to allocate dollars to activities that are being performed under the auspices of other activities; more fluid funding streams would enable fiscal flexibility. For example, if an HIV Prevention staff member is conducting an STD Investigation, the time allotted to conduct those activities should be able to be funded through STD funds. Another example could be DIS field staff conducting PCRS services that could be funded by HIV prevention/ services dollars.
- Allow and encourage flexibility with categorical funding such as allowing us to provide budgets with expanded line items so that if additional dollars become available we can expense dollars on the state end (most of us have many limitations with carry forward and additional spending requests to be compliant with FSRs etc. and accounting requirements; Arrange for group contract with HCV testing (e.g., home access), Allow testing to be funded in surveillance and epidemiology grants;. Require Hepatitis coordinator to be involved in surveillance follow-up ensuring opportunities for vaccines, education and referrals are made; Provide a line item for Hepatitis integration activities in STD, HIV, Hepatitis Enhanced Surveillance, etc that helps to fund Hepatitis prevention activities, equipment needs or personnel.

4. What funding flexibility is needed or desirable?

- It would be ideal to have funding that is flexible enough to be spent on a variety of programs (HIV, STD, And Viral Hepatitis), yet specific enough to clearly identify programs that funding may be spent on (testing, treatment, trainings, vaccine).
- Less earmarked funds, allow programs to fund integrated services

- Current flexibility offered is adequate. States need to retain as much flexibility as possible to optimize resources.
- There is little funding to support hepatitis activities so this is difficult to answer, however the flexibility to use STD and HIV federal funds to support trainings (provision of meals to attendees, travel expenses and honorarium for speakers, etc) would increase our ability to reach more difficult audiences such as health care providers.
- At least a subset of "pooled" funds that would at minimum allow for joint testing/screening as appropriate. In some states the HIV and STD programs are under one administrative umbrella. Seemingly it would not be difficult to set up a fiscally pooled testing strategy that might make integration at the front-line level easier.
- Include hepatitis in other Plans such as Epidemiology Profile, State Plans for HIV, STD, etc. Education Curriculum with DASH dollars, Immunization Plans, 317 funds, etc.

5. What are the most important ways that the Center should modify Funding Opportunity Announcements to better strengthen program collaboration and service delivery?

- We need to start with a dialogue with states about this. The assessment I mentioned earlier may help this dialogue, but let us keep in mind that states are very apprehensive to agree to integration language that gets incorporated into announcements when the dollars do not follow. I would need assurances here that language incorporated into announcements would not be mandated without funding. With this said I am an advocate of consistent language in each announcement that speaks to integration. We do this now as indicated by the STD grant and the HIV grant integration requests by CDC. No funding is attached to this but CDC implies this integration is a necessary component of funding.
- Spending on specific viral hepatitis and STD programs (i.e., education, prevention case management, trainings, and testing) should be allowed and encouraged in the funding announcements. Demonstrated integration efforts by the jurisdictions should be mandated in the funding announcement. All programs within the Center should coordinate their funding announcements to facilitate communication and collaboration between each respective state program applying for the funding.
- Require and promote integration activities, work with HIV surveillance to integrate. Develop program announcement with input from jurisdictions who have integrated programs
- More recent CDC Funding Opportunity Announcements (i.e. Program Announcement PS07-768) have included/required program collaboration. Such requirements strongly encourage applicants to act collaboratively and include other diseases in their plans, enhancing collaboration. It would be more useful to have clearer guidance on a percentage or formula amount expected to be spent on other service areas, or inclusion of information on what might be permitted in terms of using categorical funding for other service areas. The format of all FOA should be harmonized to reflect a program plan. Programs should sign MOUs and appropriate individuals with expertise and responsibility in each of these integration areas – at the state and federal level – should read and provide input on each other's grants.
- Consistency across funding streams in terms of standards and/or requirements related to program integration at all levels of services (i.e., client-level and administrative/state level) and reporting requirements.
- Consider requiring specific hepatitis collaboration activities as part of the funding criteria
- Overtly discuss fiscal collaboration and alleviation of funding restrictions. AND be clear in those communications. Unfortunately, sometimes CDC communicates in a tautological manner, such that clear, concise menus of options is not provided nor are priorities clear.

- Funding opportunities could require that responses have to include a component/ response of how programs implement or intend to implement PCSI and that PCSI is to be deemed as an essential core component across all programs (HIV/AIDS, STD, HCV, etc.) Additionally, timeline coordination of FOA's between grants would be helpful.
- Line item in budget for Hepatitis prevention activities requiring a performance measure to work with Hepatitis coordinator and input or lead from coordinator on activity (ies); Integrate hepatitis personnel and activities in grant language, performance measures, outcomes and budget; Include HCV testing in HIV incidence project. At a minimum for all those who are HIV +, run blood for HCV status.

Domain II. Implementation/Program Policy

1. How can CDC assist states and local jurisdictions best in the implementation of PCSI?

Identify Specific Resources for PCSI

- Provide financial assistance to ensure that integration efforts are funded and supported. Put the money where their mouth is....if you want integrated services at the local level, then fund it. These funds need to be delivered on a continuous basis over 3-5 years to ensure that integration efforts are sustained. One-time funding does not support the staff needed to actually do the work of integrated health services delivery.

Set Example of PCSI at/from CDC

- Encourage state and local integration of programs, removing barriers of categorical funding. Joint site visits from HIV and STD CDC project officers. In states with more than one jurisdiction assign same project officer to all sites.
- By setting a good example @ headquarters: - currently each categorical grant is handled differently - Divisions are not familiar with each others programs
- It all starts at the CDC. They must integrate these programs so that the integration is clearly visible to the states. For instance, instead of each state TB, STD and HIV program having its own CDC liaison, there needs to be one or two CDC liaisons for the three state programs. One CDC person that is looking at the integration of the states STD, HIV, TB and HEP programs.
- By example. Integrate better on the federal level in terms of requirements and activities.
- Demonstrate their own capacity to collaborate, integrate and share activities and successes; Send out joint letters to jurisdictions of goals Update on collaboration activities within CDC; Improve current communications to be consistent; Create "one voice" within CDC
- Model integration at their level. Walk the walk. HIV/AIDS Surveillance and HIV prevention are inconsistent in data collection variables; STD and HIV at CDC don't even seem to know each other.
- CDC needs to integrate first, before preaching before local jurisdictions on the need to integrate.
- Improved cross-branch/division alignment of funding streams and associated requirements, performance measures/methods, program standards and training/capacity building activities.

Other Recommendations to CDC

- CDC may want to come out with "Recommendations" to medical providers on how to integrate.
- Coordinate with other relevant federal agencies to facilitate integration and resources to address the needs of clients that may be identified (e.g., to expand Hepatitis treatment

providers); collaborate and integrate with HRSA and SAMSHA and to require PCSI in their administrations.
- Develop DEBIs to include integrated prevention interventions, or adapt existing DEBIs to include integrated prevention interventions
- Integrate the trainings CDC develops (e.g., the STD disease intervention specialist (DIS)/communicable disease investigator training is extensive and thorough and may be a good starting place developing integrated trainings
- Revise the HIV prevention community planning guidance to include expectations and guidance on how to conduct integrated planning activities
- Allow and encourage flexibility in how federal assignees work across programs and communicate this flexibility. For example, in an integrated program an STD DIS will need to be able to work in HIV, Hep and TB
- Fund PCSI positions and/or assign CDC employees in jurisdictions with large public health systems to assist with collaboration and integration

Data Systems
- Coordinate data collection variables and tools. At a minimum this should include hardware specifications and compatible software platforms.
- Ideally, CDC should provide guidance related to integration of surveillance systems and data sharing in the context of Federal and State legislative restrictions.
- Work with HIV surveillance to integrate.

Flexibility in use of Funds
- Allow more flexibility with grant funds. When integrating programs, it is important for certain staff to be funded by multiple sources. A good example is DIS. Should be funded from STD, HIV Prevention, and HIV Surveillance
- Show how funds may be used to support each other if some of the same work is being performed by one person. Encourage programs that are joint based e.g. community activities.
- Come up with a list of clinical prevention practices based upon the US Preventive Services Task Force reports.
- Eliminate silo funding and disease-specific performance measures/ targets. Reframe on patients served and availability of prevention package.
- Encourage, but not require, jurisdictions to use of carryover funds to support collaborative or integrated activities.

Pilot Projects
- Joint funding pilot projects outside of the current funding streams. Such as joint HIV and TB funded project, joint STD/HIV funded project.
- Fund multi-year projects that support integration efforts. Integration efforts cannot be expanded if it is not funded because there is no staff to perform the work.
- Provide financial incentives to programs that seek to integrate preventive services into their programs

Facilitate Sharing/Technical Assistance/ Provide Training
- Continued planning calls, workgroup meetings and at least bi-annual webinars providing all states with information from model integrated programs.
- Project Officers should make integration a priority and work with their contacts in the states to assist with integration efforts.
- Expand opportunities by facilitating quarterly or bi-annually webinars that illustrate best practices of PCSI in urban, rural, and territories across the United States.
- Support quarterly or semi-annual regional planning meetings among STD, Viral Hep, TB, and HIV/AIDS Directors to discuss and address this issue.
- Provide annual networking meetings that are integrated. Perhaps link hepatitis meeting with National Immunization conference or the HIV conference; Perhaps have STD, HIV, Immunization and Hepatitis all meet during the same week with special breakout sessions for each and encouraging collaborative presentations stressing policy and public health strategies.

- Conduct learning tours mentioned on previous page
- Provide TA to programs that seek to integrate other preventive services into their programs.
- Strengthen the ICCR system by maintaining a current list and providing training
- Emphasize interviewing and investigation skills and the importance of the DIS. More funding help facilitate reporting from VA, IHS, etc.
- Provide technical assistance regarding all legal issues surrounding PCSI

2. What restrictions on use of federal funds should the Center strategically tackle that would better support service integration if they were removed? What funding flexibility is needed or desirable?

Flexibility in Funding and Use of Staff

- Programs should be able to allocate dollars to activities that are being performed under the auspices of other activities; fluid funding streams would enable fiscal flexibility;
- Remove all restrictive language around abstinence, condoms, and needle exchange Funding flexibility for present grant application should have no restrictions on HIV funding STD services or STD using grant dollars to fund a DIS who does both STD and HIV.
- Allow a subset of "pooled" funds that would at minimum allow for joint testing/screening as appropriate. In states where HIV and STD programs are under one administrative umbrella; it would not be difficult to set up a fiscally pooled testing strategy that might make integration at the front-line level easier.
- Remove restrictions on STD funding being used for HIV prevention. Make it very clear that HIV prevention funds can also be used for prevention of other STDs (has been confusion on this in the past).
- Allow testing to be funded in surveillance and epidemiology grants
- All the grants have restrictions. Unless required by law restrictions should be lifted so resources can be shared and project areas can decide how best to use the funds
- Desirable funding flexibility would be to have block grants vs. cooperative agreements; allow funding of integrated services, eg testing and reimbursement for syphilis in person at risk for HIV with funds out of a HIV funding agreement
- Seamless use of HIV/STD/TB/hepatitis funds for service delivery without regard for disease-specific targets. Allow recipients to prioritize Center block grants based on local epidemiology
- Explicit approval for STD staff to perform PCRS functions.
- CSPS should be available to pay for medication to treat STD

Other Comments/Concerns

- CDC will also need to work with HRSA to ensure that Care and Treatment are fully integrated with these integration plans.
- Current flexibility offered is adequate. States need to retain as much flexibility as possible to optimize resources
- If you allow flexibility within the current format, HIV will get the bigger push, leaving STD and Hepatitis in trouble
- Address 340B regulations to include VACCINES to prevent Hep A and B and HPV and to allow agencies like HIV CBO's, for example, to utilize 340B meds even though they are not a "clinic" and their clients are not necessarily our "patients"
- Work with Title X to remove barriers to providing EC and contraception in STD clinics - paperwork, financial requirements, training issues, etc. CDC needs to present the evidence for effectiveness of syringe exchange to lawmakers to overturn the federal ban
- The restrictions on use of HIV prevention funds are okay to keep the focus on HIV. STD programs just need more money to do their job.

3. What are the most important ways that the Center should modify Funding Opportunity Announcements to better strengthen program collaboration and service delivery?

Program Announcements/FOAs

- Use consistent language in program announcements (e.g. "partner services" vs. "PCRS").
- Ensure consistency in performance measure language and variables.
- Funding opportunity announcements should not be block (e.g. one grant for HIV, TB and STD). This would play out differently at the State level where the weakest program would lose money.
- Better timeline coordination of FOA's between grants could be helpful
- I would like to see a fairly straight forward Funding Announcement like the one that Vaccine Preventable Diseases produces. The CDC states what the priorities for an effective program are clearly and the states have to create objective around that priority. Often times I think that the STD grant is unclear in what is important or very vague. The states create objectives in which we are unsure if they are really addressing the CDC's priorities
- CDC could: develop a national plan/roadmap; assist in implementation of this plan through appropriate grant language;
- All programs within the Center should coordinate their funding announcements to facilitate communication and collaboration between each respective state program applying for the funding.
- Provide more time to respond to RFPs

Recommendations on Integration and FOA's

- Program integration must be clearly stressed in the Program Announcement with priorities and timelines.
- Require FOA responses to include a component of how programs implement or intend to implement PCSI.
- Deem PCSI as an essential core component across all programs (HIV/AIDS, STD, HCV, etc.)
- Develop FOAs that support integrated activities and collaboration between STD, TB, Hepatitis, HIV.
- Require collaboration among all the programs and see what the states come up with; require co-signature of various program directors
- Emphasize cross-cutting activities that can be funded (e.g., STD prevention with HIV cooperative agreement funds and vice versa).
- Require integration narratives with specific questions answered to shape how programs plan for integration.
- The format of all FOA should be harmonized to reflect a program plan. Programs should sign MOUs and appropriate individuals with expertise and responsibility in each of these integration areas - at the state and federal level - should read and provide input on each other's grants.
- Reduce administrative burdens to program staff , for example, each program may not need to separately describe integration and coordination activities in their respective progress reports and applications. CDC can then share the relevant narrative across it's program areas
- Encourage and allow spending on specific viral hepatitis and STD programs (i.e., education, prevention case management, trainings, and testing) in the funding announcements.
- Develop one announcement combining all programs; budget that is not subdivided by program; Combine similar activities into one funding opportunity
- Eliminate multiple proposals changing to one single Center level proposal every 5 years with annual opportunities for special supplements based on Center priorities

- Marry the reporting requirements across the board and utilize one reporting tool for all.
- True service integration would ultimately mean removing barriers imposed by categorical funding, putting different services (i.e. HIV, STD, Hepatitis and TB) on similar cooperative grant schedules, and asking health departments to work collaboratively on cooperative grant proposals. Program reports should be based on shared collaborative objectives putting different services (i.e. HIV, STD, Hepatitis and TB) on similar cooperative grant schedules, and asking health departments to work collaboratively on cooperative grant proposals. Program reports should be based on shared collaborative objectives

Funding

- Basic funding opportunities should remain the same. However, if there are specific ideas for program funding they can be submitted by areas jointly, that have the same or very similar targets, services in mind.
- Allow funding of integrated services, regardless of cooperative agreement
- Allow and encourage flexibility with categorical funding such as allowing us to provide budgets with expanded line items so that if additional dollars become available we can expense dollars on the state end (most of us have many limitations with carry forward and additional spending requests to be compliant with FSRs etc. and accounting requirements
- Require certain level of funding to partner services based on HIV and STD rates
- As long as funding is delivered by disease category, then form will continue to follow the method of funding.
- Allow flexibility based on local data and circumstances
- HIV funds, when available should be allowed to be used for hepatitis projects. Current restrictions make this difficult if not impossible. HIV funds cannot currently be used to purchase HAV or HBV vaccine, despite the recommendation for vaccination for HIV+ persons and the overlap of risk populations In addition, influence over the restrictions set forth in grants such as the SAMHSA 5-year HIV/ Substance abuse/ and Hepatitis, where there are restrictions against vaccine purchase would be very useful in the success of those programs.
- It would be useful to have clearer guidance on a percentage or formula amount expected to be spent on other service areas, or inclusion of information on what might be permitted in terms of using categorical funding for other service areas.

Other Comments/Concerns

- Ensure that performance measures are consistent with established data collection systems. Build data systems from bottom up, not the other way around.
- The semi annual progress report is due too close to the end of the reporting period.
- More recent CDC Funding Opportunity Announcements (i.e. Program Announcement PS07-768) have included/required program collaboration. Such requirements strongly encourage applicants to act collaboratively and include other diseases in their plans, enhancing collaboration

Domain III. Performance Indicators/ Strategic Information/ Evaluation

1. What key indicators of service integration can be derived immediately from existing data sources?

Suggests for Specific Analyses

- number of hepatitis A and B vaccines distributed to STD clinics and to community organizations receiving HIV prevention funds;
- proportion of HIV prevention grantees delivering hepatitis C testing;

- proportion of HIV program staff and HIV grantees trained on the basics of viral hepatitis and STDs; proportion of HIV prevention grantees offering hepatitis and STD educational information; proportion of STD clinics offering HCV and HIV testing, and hepatitis A and B vaccine; number of counselors able to offer both HIV and HCV testing
- Proportion of Hepatitis A & B vaccinations that are provided at STD Clinics; Proportion of FTE's in Health Departments that are cross trained on HIV/AIDS, STD's, TB and Hepatitis C; Number of Hepatitis C tests that are currently being performed at supported HIV testing sites; Number of STD screening referrals that are being provided at HIV CTR Sites; Portion of current Guidelines from Health Departments that have had collaborative input in the creation of the document.
- # newly identified, prevalence of hepatitis; Mortality data related to hepatitis (most likely secondary ICD 10 codes; immunization data of youths especially in universal vaccination states; Unvaccinated high risk college and higher education populations that need vaccination, epidemiology of # of liver transplants and those on list for liver transplantation indicating trend over time for increased need and severity of illness; Number of insurance companies that cover adult Hepatitis vaccination and dollar amount spent, compare to cost savings for those who need treatment; Number of incarcerated persons, estimating Hepatitis C status and need for adult vaccination of Hepatitis B (and A); Number of know HCV incarcerated persons, number and percent in treatment; Number of people in methadone maintenance programs; Test all newly infected HIV persons for HCV status to capture Co-infection rate.
- Performance indicators plus number of individuals at Health Dept. funded services that receive Hep, STD, HIV, and TB services.

Existing Data

- A review of the performance indicators of the prevention grantees may be in order to appropriately answer this question.
- Co-morbidity cross matching, available resources and Partner Services integration, community assessments and community planning group plans
- Epidemiological data from states certainly provides an overview of what incidence and prevalence is occurring. These data however do not provide accurate assessments of what isn't measured in states (i.e. not all states have unduplicated viral hepatitis - especially C - data sources, most states don't overlap care with HIV reporting DB's, and STD db's are often separate yet). These data sources also, in many cases do not provide information on co-infection. Alternatively, high-risk target-population HIV testing data may provide a good indicator of how well states (and its local jurisdictions) are on the pulse of high-risk groups in the state. In other words, if the highest-risk persons in states are being tested for HIV (and perhaps other diseases) this could serve as a proxy for the availability of the appropriate infrastructure to begin/maintain integration efforts.
- Ryan White Part C entities collect and report Hep C screening and testing, and Hep B vaccinations for people living with HIV.
- Aside from the obvious notion of multiple occurring disorders in our incidence and prevalence data--we can also infer information from target population data; e.g., adolescent data, communities of color, etc.
- Cross matching of existing databases such as hepatitis, HIV, syphilis, STDs, TB, and refugee health. In addition, non-identifying data derived from substance abuse intake screenings and health assessments could be of value in determining the needs of this population

HIV

- Newly diagnosed with HIV that are linked to care
- Proportion of HIV positive with known TB
- HIV prevalence of STD clients
- Number of STD screening referrals that are being provided at HIV CTR Sites.
- # of TB tests provided to HIV cases

STD

- HIV prevalence of STD clients
- Proportion of STD clinic attendees who receive Hepatitis B vaccine
- HIV testing in STD clinics settings
- Proportion of Hepatitis A & B vaccinations that are provided at STD Clinics

TB

- Proportion of HIV positive with known TB
- # of HIV tests offered to TB cases.
- % TB patients with HIV test result. %HIV+ tested for TB, started on LTBI therapy, completing LTBI therapy.
- Identification of TB patients tested through HIV testing sites. HIV/TB co-infected patients are enrolled in care for both disease processes.
- Fund TB programs appropriately so that we CAN give Hep B immunizations and CAN have regular, planned, meetings with HIV/STD.

Viral Hepatitis

- Annual Hepatitis C screenings
- Proportion of Hepatitis A & B vaccinations that are provided at STD Clinics
- Data available
- STD*MIS can pull joint STD/HIV cases. I assume the STD Performance Measure Database can easily be updated to address integrated measures
- For sites using STD MIS, disease intervention information is available for HIV clients and partners. Local HIV testing data system collects Hep C testing info.

Other

- To answer this would require an analysis of existing performance indicators by the workgroup identified from the federal task forces suggested in question 5.
- Proportion of FTE's in Health Departments that are cross trained on HIV/AIDS, STD's, and Hepatitis C. - Number of Hepatitis C tests that are currently being performed at contracted HIV test sites.
- Portion of current Guidelines from Health Departments that have had collaborative input in the creation of the document.
- Funding source for each position and contract.
- Survey as to who makes decisions on expenditures.
- HIV partner management indicators from STD*MIS - or similar database, if STD/HIV integrated.
    - msms who are tested for HIV and are also tested for syphilis
    - disease intervention index contact index
    - compare geographical or county data on women eligible for Title X
- Client usage data HIV-Hepatitis-TB-STD co-infected patients receiving all services (e.g., previously infected HIV named in PCRS for syphilis)
- Percent of patients receiving STD/HIV/hepatitis/TB/substance use/mental health services per visit
- Through cross-matching, the % of HIV-reported cases that are subsequently diagnosed with Hep A or Hep B.
- Numbers of those dx with STD that receive an HIV test or know their status
- This is going to vary widely from one jurisdiction to another and I would caution that any kind of "global" conclusions would be limited in scope as to accessibility of data. Maryland, for example, is one of the last states transitioning to name-based HIV reporting with a mandated goal of having reporting laws and regulations finalized and in place by spring 2008. The full impact on changes to current surveillance systems and data reporting is not yet known. Within local health departments in the state there is close collaboration between TB and HIV programs in referring individuals between them who are considered at risk. However, there is no data that is available at this time, other than anecdotal reports at the local level, of individuals who are tested within the private

sector and referred to the public sector for either HIV or TB testing as to numbers, demographics, etc.

Suggestions for databases

- Registry cross-matches can improve surveillance for active TB and HIV.
- We obtain this by matching TB data with HIV data to look for co-infection.
- Building a disease intervention/surveillance information system for sites using TB TIMS, STD MIS would be beneficial to program working with populations that share disease relations, ie, TB/HIV, TB/Diabetes, TB Substance Abuse, TB/Homelessness. A common database that would include the links to variety of diseases/conditions would be help in intervention development, surveillance and data collection and analysis.

2. Which indicators should be prioritized and developed for monitoring and evaluating PCSI (e.g., proportion of HIV-infected with known TB status; proportion of STD clinic attendees who receive Hepatitis B vaccine; proportion of those newly diagnosed with HIV that are linked to care)?

General Comments

- The degree to which clients receive integrated services in one location.
- Clients' knowledge of their HIV/STD/HCV/TB status.
- Strategically, focusing on HIV-infected persons, especially those enrolled in publicly-supported care services, receiving a full range of recommended services makes the most sense insofar as the data systems are more robust.
- Integrate data collection at CDC level - develop system compatibility

Cautionary Notes

- Again, proceed with caution...resources are key to the development of this plan. I certainly agree with the examples, yet to what end should we evaluate this information? Another PEMS???
- Unfortunately due to database non-compatibility issues mentioned above, co-infection data may provide misleading information. Meaning, proportion of HIV-infected with known HBV or TB status may simply be a function of one or two educated nurses in the HIV care side of things and have absolutely to do with state-wide integration. Or it may be that there is a wonderful Ryan White Case Manager who is really on top of TB because they used to work in a TB-endemic area and has nothing to do with the State or local health jurisdiction policy/implementation of integration. Epidemiological data, in most cases, cannot tell you what is occurring programmatically. Program evaluation and monitoring is the best avenue for appropriate integration measurement. Key indicators, again, would need to be process as well as outcome. I.E. Number of family planning clinics in the local health jurisdictions who received high-risk adult Hepatitis A/B vaccine from the State Immunization program and how many doses were administered monthly, quarterly or yearly as indicated in their jurisdiction-specific immunization database (IE: In our state while the children's vaccine database is statewide, adult immunization db's are local health jurisdiction-specific and cross-county lines) adult vaccine information cannot be shared. Thus an integration indicator reflecting the total number of adults receiving the full 3-twinrix series is impossible to measure concisely (particularly for marginalized/transient people).
- Do not use the number of STD clients who receive Hepatitis B vaccine, because most younger persons are already vaccinated. Proportion of HIV-infected with known TB status, Number of persons with HIV who are reported with and STD, record change over time. The evaluation of the people who are co infected is easier than identification of testing done on those positive for HIV, TB, STD, or Hepatitis.
- All of your examples are good. For the first one, one might have to limit it to those enrolled in Case Management. Rapid referral into care is critical. As prevention dollars remain level or reduced, HIV Care continues to be well funded. It is important to

collaborate or integrate with Ryan White Part B programs to supplement testing and staff - such as DIS to get people into Case Management quickly.

- First, they must have a basic understanding of what PCSI is and why it is necessary from the Center's perspective. Second, they should look to the examples of success developed by their C coordinators, and other entities within their state regarding successful integration activities and then be evaluated accordingly. A one-size-fits-all state integration evaluation system won't work, different states have different strengths and weaknesses, thus what states and local jurisdictions should be doing will vary depending on funding, culture, and overt support from CDC.

HIV

- Proportion of HIV positive clients receiving hepatitis testing and prevention (vaccine),
- Of those receiving HIV testing, number also receiving testing for syphilis and other STDs.
- For new HIV positives, number referred to care services, syphilis status, TB status.
- Proportion of HIV infected with known TB status
- HIV patients with TB skin test information reported.
- Proportion of HIV positive with known LTBI that start of preventive treatment
- Proportion of HIV infected persons tested and treated for latent TB infection

STD

- Proportion of STD clients receiving HBV vaccine,
- Proportion of STD clinic attendees who receive Hepatitis B vaccine
- For those with P&S syphilis, what is HIV status?
- Proportion of syphilis infected with or having tested for HIV.
- Numbers of those dx with STD that receive an HIV test or know their status
- Proportion of STD clients with known HIV, TB and Hep B&C status.

TB

- For TB+ (active and latent), what is their HIV status.
- Proportion of TB clients (LTBI, disease) with known HIV infection.
- Percent of TB patients (all ages) with known HIV status. Percent of HIV patients with risk of TB who receive annual screening for TB. Percent of HIV/LTBI patients who complete treatment.
- How many individuals, when diagnosed with TB are newly diagnosed with TB?
- Proportion of TB suspects and active cases for whom the HIV status is known.
- Proportion of TB cases and suspects who are offered testing for HIV (note: even if testing is offered, patients do decline)

Viral Hepatitis

- For those seen in STD clinics or HIV testing providers, those provided Hep B vaccine
- Hep B vaccine status of known HIV infected persons.

Follow up and Linkage to Care

- Number of clients completing partner services and linkages into services
- proportion of those newly diagnosed with HIV that are linked to care
- Additional Data Collection/analysis
- Include Hepatitis knowledge and risk factor questions in BRFSS, NAHANES, surveys;
- Look at hospital mortality data and ER admission data to include drug use, overdose, withdrawal as codes; Increase adult vaccination dollars; Include care and treatment dollars for HCV with other funding sources such as HIV, Community Health Centers, DOC, etc
- Number of contractors that do more than one categorical activity.
- DIS productivity measures that cross-cut the various programs.
- Newly diagnosed HIV that are linked to care via PCRS from a DIS.

- Indicators should incorporate population utilization of prevention services (% women < 25 receiving basic prevention package); Prioritize those receiving current HIV CTL to get concomitant STD/hepatitis/substance use services

Populations and Risk

- Number of immigrants and refugees testing positive for HBV and HCV as well as those accessing care.
- Some priority populations could be, but not limited to: All newly diagnosed HIV posiive individuals, with an IDU risk histories that are aware of their HCV status; Proportion of initially diagnosed syphilis cases (710-750) that are aware of their HIV status; Proportion of HIV infected with known TB status.
- Capture burden of hepatitis in high risk populations such as immigrants, medically underserved, homeless, shelters, re-entry population, incarcerated, military. This would help with a more accurate description of the burden of hepatitis, especially HCV;
- Some priority populations could be, not limited to: - All newly diagnosed HIV positive individuals, with an IDU risk histories that are aware of their HCV status. - Proportion of initially diagnosed syphilis cases (710-750) that are aware of their HIV status. - Proportion of HIV infected with known TB status.
- For IDU, those testing for HIV, syphilis and Hep C. For clients in STD and family planning clinics, those tested for HIV, syphilis, GC and CT.
- MSMs who are tested for HIV and are also tested for syphilis
- Proportion of HIV CBO's clients who are referred to STD clinics or are offered STD testing (and Hep testing/vaccine...).
- Related risk factors across co-infected individuals.
- Proportion of women attending STD clinics who receive contraception or referrals, proportion of IDUs attending STD clinics who are linked to syringe exchange programs, tested for HIV, hepatitis C, immunized against hepatitis A and B.

Other Comments

- Mortality data - How many individuals died from TB who also had HIV?
- The proportion of HIV-infected patients in care who receive appropriate screening and vaccination; documenting referrals to PCRS and adequate prevention for positives interventions is more of a challenge, but very important. In order for indicators to be meaningful across programs, harmonization of data elements across service program data collection forms needs to occur. Again, the bigger challenge is sharing these data in a way that assists in minimizing repeated questions to clients, enhances analytic opportunities, and maintains strict confidentiality adherence.
- I think you need to get more information about what data is even available and how it is available before you can specify specific parameters and prioritize them. Do the national surveillance systems currently in existence allow for the capture of detailed enough information that you could link STD clients with Hep B vaccination and with HIV testing?
- Are there even parameters that could be considered "universal" enough between programs to focus on? Perhaps the August meeting will be helpful in this regard.
- Proportion of HIV program staff and HIV grantees trained on the basics of viral hepatitis and STDs

Domain IV. Surveillance and Data

1. What surveillance barriers/facilitators exist that might support or hinder PCSI?

Data Sharing

- Categorical surveillance activities need to be fully articulated and understood before I answer this. For example, barriers exist when data sharing is needed for the simplest reports and/or for writing CDC integration goals. So I guess that's the barrier I'd like to address first and that is the categorical barriers associated with integration from a surveillance perspective.
- Data sharing rules, HIPPA protection policies, shortage of personnel to process large data examinations such as those listed above. The restriction that AVHPC will not be able to take part in any surveillance activities
- Rules regarding data transfer not keeping pace with technology.
- BIG Barriers: I do not personally believe any of the surveillance systems are compatible immediately for cross categorical reference.
- Match between AIDS and TB registry's are very important. In our state the hardest part to success of this match was follow up on known TB cases reported in AIDS registry but not TB registry. Barrier is TB programs denied access to HIV/AIDS programs information on patient.
- Programs that do not have shared databases at the local level. Programs should not need to ask each other for access, it should be part of doing business to have shared access.
- [lack of] Access to HRSA data (ie CADR)
- Categorical surveillance and data systems can create barriers to sharing information and data with intervention and prevention program relevance.
- The lack of compatible data systems that have no linkage is a barrier to prevention and control of diseases. In Texas we have TB TWICES, CDC TIMS, STD MIS, HARS and the list goes on. A multi-million dollar investment with no communication links from one program to the other.

Laws and Policies

- Data sharing rules, HIPPA protection policies, shortage of personnel to process large data examinations such as those listed above. The restriction that AVHPC will not be able to take part in any surveillance activities
- The separation of HIV testing from other types of medical services and tests may pose a barrier. The laws in place regarding the protection of HIV/AIDS data make the possibility of linked databases complicated or impossible.
- Data sharing rules, HIPPA protection policies, The restriction that AVHPC will not be able to take part in any surveillance activities
- HIV has not been able to relinquish individual data - just the aggregate.
- There are no statewide policies that focus on, encourage or stipulate a need for programs to assess and/or consider integration of services, avoidance of duplication and etc. with regard to data collection and/or surveillance.

Issues of Compatibility in Systems

- CDC and state surveillance systems for HIV, STD, TB and hepatitis are all different and cannot be merged.
- Datasets should have similar content, structure and identification of fields.
- Incompatible data systems create barriers (STD MIS, HARS, etc).
- Match between AIDS and TB registry's are very important. In our state the hardest part to success of this match was follow up on known TB cases reported in AIDS registry but not TB registry. Barrier is TB programs denied access to HIV/AIDS programs information on patient.

- Different data systems. HARS for HIV/AIDS. TIMS for TB. MSDIS for STD. NEDSS that now will not have any PAMs to connect TB or STD with NEDSS. It's a mess
- system compatibility - confidentiality

Form and Structure

- Additionally, in Our state, a barrier is the use of separate HIV and AIDS reporting forms
- Immunization clinics not being with the STD?HIC clinics.
- "Siloed" surveillance programs can create barriers to sharing information and data with disease intervention/prevention programs.
- Multiple databases
- The epidemiologist of these programs are in silo's often and don't always have an understanding of the other diseases, especially on the local level.
- Too many systems with too many differing requirements in each. HARS, EHARS, Pems, XPems, STD*MIS.....Can a NEDSS system capture them all?
- Double reporting - copious amounts of paperwork by HIV AND STD Programs etc
- many different data systems even within one department
- Each [disease] has its own surveillance system
- Currently there is no integration of surveillance systems
- Disparate data systems

Communication

- Creators of EHARS and PHIN-MS not communicating,
- Separate and uniquely funded surveillance systems; vastly different surveillance cultures/attitudes/experience; lack of use of HIV surveillance for prevention services, ie, partner services
- Reluctance, low priority of AIDS or HIV registry to match with TB registry. Need this information to prioritize TB contacts for investigation at local level
- Lack of willingness of HIV registries to share data with TB and STD registries.
- HIV has not been able to relinquish individual data - just the aggregate.

Infrastructure Problems: Personnel, Funding, Technology

- Shortage of personnel to process large data examinations such as those listed above.
- The epidemiologist of these programs are in silo's often and don't always have an understanding of the other diseases, especially on the local level.
- Barrier: Lack of funding for viral hepatitis-specific epidemiologists in states.
- Would also caution that many state TB programs have only one or two epidemiologists available to them for the entire state-wide program as compared to HIV?AIDS programs which have had the larger influx of public funding to help support infrastructure.
- Data systems are still paper-based in many jurisdictions. Programs need data entry support in order to obtain these data. Education and training of staff on the importance of integration efforts.
- Surveillance for all of these diseases in the US need increased funding. Funding from the National Coordinating Center for Health Information Service (CCHIS) should have language that directs states to spend this Information technology funds on database infrastructure for HIV, STD, TB, and Hepatitis.
- "Siloed" surveillance programs can create barriers to sharing information and data with disease intervention/prevention programs.
- Antiquated data collection systems (e.g., those that are still DOS based).
- Insufficient IT support for systems such as STD*MIS, and "PEMS"
- Separate and uniquely funded surveillance systems
- Systems are outdated and technology challenged.
- Declining funding with resultant decrease in staffing negatively impacts a Program's ability to implement new integrated activities.
- Collecting data without analysis at the local and state level is a barrier to surveillance and interventions.

- In our state, the TB program is currently uncertain as to what will happen when TIMS is no longer supported, but reports data to CDC through TIMS. There is currently no state support for additional IT assistance or funding to even address this issue.

Suggestions

- Develop and pilot integrated surveillance and case management system that will facilitate data sharing and will adequately meet the complex need and consider different business requirements of each program.
- Focus on facilitating electronic reporting and support Partner Services across all programs
- IF integration is truly a CDC desire, then a Hepatitis-specific epidemiology person would join the HIV epidemiology section or other epidemiology section as appropriate. Facilitator - intelligent, hard working epidemiologists who have creative ideas about how DB's or systems can link together to provide comprehensive epidemiology data.
- Support integration with prevention (e.g., education messages, include input in case definitions, surveillance follow-up, referrals, vaccination and care; Use data to help identify geographic areas and target populations for prevention activities (GIS mapping) and also include surveillance as part of evaluation outcome measures
- Datasets should have similar content, structure and identification of fields.
- Cross-matching analysis should be highlighted and supported.
- Not collecting risk information for hepatitis C hinders our ability to best determine service integration; An integrated program allows for in-house data analysis among all programs (HIV/AIDS, STDs, and hepatitis C
- Chronic Hepatitis C is not reportable.

Other Comments

- The AIDS Administration is currently dealing with surveillance issues related to transitioning to name-based HIV-reporting statewide and the impact on local reporting requirements.
- It is important to remember that surveillance is a support program - to collect, analyze, and disseminate specialized data to the programs with a need. Barriers should not be acceptable.
- Need integrates surveillance for HIV and STDs
- The STD program has been told STD-MIS will be supported for another 3-5 years. Hepatitis is currently being reported through NEDSS.

2. What are priority recommendations for surveillance/strategic information collection at local, state, and national levels to support PCSI?

Standardization

- Developing standardized policies and procedures, where it makes sense, for active and passive surveillance activities.
- Standardize risk assessment and data elements across programs to be able to make meaningful comparisons
- Breaking down barriers that do not allow data sharing
- Focus on partner services, electronic lab reporting and standardized data collection
- Harmonization of data elements across various service program data collection forms needs to occur. Redundancy of data collection efforts should be eliminated
- Very careful consideration of every single data element collected so that only data that will be used are collected.
- For clinical services, expectations/requirements about reporting cross-disciplinary activities (e.g., HCV testing in STD clinics) should be brought into alignment such that there is comparability and consistency in data collected.

- Establish a few key data elements that should be collected on all patients with STD, HIV/AIDS, HEP, and active TB. Keep it simple at first. Get the players at CDC used to working with each other.

Systems

- Redundancy of data collection efforts should be eliminated and web-based systems should be able to allow data entry from related programs
- Marry reporting requirements wherever possible and work together on the national level to offer specs for one system that can be built locally to capture all data needed for all systems.
- Updating data collection systems, improving compatibility.
- Demonstration projects of integrated electronic surveillance and data management systems. E.G., patient comes into an STD clinic, data on HIV status, hepatitis and TB history immediately available
- Mandate shared data for these programs. There could be funds for interfaces to allow each separate program to see key fields from other units.
- CDC should require registry matching to help eliminate barriers to HIV and TB registry matching
- Require state level matching of HIV/TB/STD registries.
- Combined surveillance forms, systems
- Updating data collection systems, improving compatibility between program data systems would benefit communication, surveillance and information sharing.

New/ Enhanced Data Collection and Analysis

- Chronic Hepatitis C is not reportable. Need a Hepatitis C registry
- There is currently a significant need for a standard for Hepatitis C reporting to be instituted.
- Information about chronic care and demographics would be extremely useful in planning interventions
- Better viral Hepatitis C epidemiology data including risk factors. Ideally, in my opinion a DIS function within the realm of HCV would be supported by the Center. This type of work could advance our understanding of sex/drug networks in relationship to HCV and most-likely other disease transmission (and ultimately prevention information.
- Additionally, all programs should begin to look at co-morbidities of HIV/AIDS, Hepatitis A, B, C, Syphilis, Gonorrhea, and Chlamydia.
- Include local BRFSS questions and YRBS questions related to viral hepatitis;
- All programs should be begin to look at co-morbidities of HIV/AIDS, Hepatitis A,B, C, Syphilis, Gonorrhea, and Chlamydia.
- Key indicators for information collection at local, state, and national levels: number of TB patients with HIV, Number of HIV with TB, Number of HIV with new STD, Number of Hepatitis B and C with HIV.
- Identify the amount of overlap in usage by clients
- Demographics, infectious period, treatment and completion, diagnostic tests and follow-up,
- How many people offered HIV testing, how many done and results.
- How many people placed successfully into medical care.

Communication

- Increasing state level and CDC level staff communications.
- Common goals and objectives would need to be determined and agreed to by service providers.
- Establish a few key data elements that should be collected on all patients with STD, HIV/AIDS, HEP, and active TB. Keep it simple at first. Get the players at CDC used to working with each other.

Data Sharing

- Encouragement/facilitation of data sharing, e.g., b/w HIV and STD systems.

- Sharing of information
- Identify and share successfully cross-matching that provides insight for program.
- Make surveillance data available to STD and HIV programs, so we know what the other program is doing
- Surveillance (syphilis and HIV) linkages for delivery of partner services (PCRS/PN)
- Mandate shared data for these programs. There could be funds for interfaces to allow each separate program to see key fields from other units.
- HIV testing information & TB skin testing information

Funding, Support, and Training

- Identify risk information for hepatitis C cases (health departments need funding to carry out hepatitis C surveillance activities);
- Also, support (technical and financial) for evaluation of specific interventions is not currently available. This is critical in proving the value of prevention and intervention activities.
- Increase adult vaccination dollars; Include care and treatment dollars for HCV with other funding sources such as HIV, Community Health Centers, DOC, etc.
- Laboratory
- Enhancing and coordinating lab reporting requirements and lab-related follow-up work.
- Electronic lab reporting

Other Comments

- Blending the program issues with surveillance is enough of a challenge, blending the notion of integrating several surveillance components with program components may be too much to take on for some.
- Again identifying state capacity here through assessments may give us an idea of what is a happening at all state level.
- Health department policy makers and locally-based service providers should be included in any decision-making process.
- Define the scope of integration efforts for programs. We know that program integration is a best practice, as it is based on the individual client needs, but what advantage is it for a program to integrate? What does it mean that a program is integrated? What are the advantages of going through the trouble of integrating a program if there is no funding attached to it.
- HEP screening of TB patients with known risk factors Hep. And identify and make available links for services for TB patients co-infected with HEP for Hep treatment and services.
- Survey what information is being shared and what is being done with it. Is the data collected for a report or is the data collected to improve services and make necessary changes.

V. Workforce Development/Training/Education

1. What are the workforce development and training needs in support of PCSI?

Cross Training

- Staff from HIV/AIDS, STDs, Immunization, TB, and Viral Hepatitis should all complete a basic training on HIV/STD/Viral Hepatitis in order to better understand connections between the infections. Training on job responsibilities of other positions in these fields would also facilitate integration.
- All Health Department staff should be trained in other respective collaborative disciplines.

- Training needs for Clinicians should be familiar with doing a risk assessment for all diseases.
- Much greater effort at cross-training, cross-experience, staff rotations thru different Divisions/ local Sections. Much greater flexibility...build a public health workforce instead of focused specialists
- Mandatory cross training events for frontline staff - with funds from the federal level.
- Cross training of staff is a good idea, assuming that there is adequate State/local staff to be trained. Years of decreasing funding have amplified this problem.
- Cross training of training staff for HIV/STD/TB/Viral Hep Prevention. Cross training of TB case mangers as HIV C/T providers.
- Strategic planning for and operationalization (e.g., program requirements, monitoring, evaluation) of integration needed at the level of program administrators/managers, beginning at state/city health department.
- HIV prevention people, while very well-meaning, dedicated, and usually very kind - in general have NO CLUE why viral hepatitis, especially C keeps "infringing on their territory". DHAP or the Center as a whole must educate not only AIDS Directors but mid-level and front-line state health department folks on WHY integration is necessary. It is wholly insufficient for this to be the burden of the viral hepatitis coordinators. Political, funding, and work-place tensions are often the result of the CDC's lack of appropriate education of these staff. The Center seems to be committed to integration across HIV, Viral Hepatitis, STD, and TB - so educating via webcasts, teleconferences, and letters about the specific intent of PCSI is absolutely necessary. By the very nature of our jobs, the Hepatitis C Coordinators, for the most part - "get it". That is not inherently true of other programs whose funding is continually more and more labile, and whose mandates are becoming more and more proscriptive.
- All Health Department staff should be trained in other respective collaborative disciplines. (For our work, this includes drug, alcohol and substance abuse as well as HIV/AIDS, STDs, Viral Hepatitis)
- Engage Public Health leaders and emerging leaders
- Train headquarters staff, train PHAs, train project area staff
- Joint leadership institute. Learning Tours. Likely other formal trainings needed that will flush out as process moves along.
- Project Officers need cross training on the relationships between diseases and populations. More project officers need to understand how public health, disease prevention and control works at the state and local level.

Culture Shifts – Awareness of PCSI

- Currently, providers tend to be disease-specific. While much progress has been made in terms of integration of service delivery, major cultural change would be required in terms of education and training for the workforce in each disease to reduce disease-specificity and tunnel vision regarding each one's categorical responsibilities. In some cases, additional staffing will be required.
- Engaging staff to understand vision of PCSI
- Understanding of the importance of sharing data with other programs to improve the patients care and not just for the purpose of collecting data and reporting the objective has been met to CDC.
- Train staff across different areas so better appreciation of different public health issues that often overlap.
- Need to have some kind of national education effort so people know what it [PCSI] is and can ask questions before I think you will have a real sense of what is needed in the field.

Specific Training Topics

- Training TB clinic staff and private TB providers in opt out HIV testing

- Need for training on how providers can integrate services for target population with co-morbidities.
- There needs to be surveillance level (epidemiologist) training for database projects.
- More cross-training and education at CDC project officer level to ensure consistent messages are delivered
- Many clinicians who work in STD programs also work with family planning Title X programs. For those who don't cross training would be relatively easy. Combine STD and Title X trainings. Educate public health workers about US Preventive Services Task Force recommendations. Which of these can or should be integrated into STD clinic visits? Smoking cessation, alcohol abuse screening, adult immunizations, cancer screening, etc.
- DIS cross training ICCR training
- prevention strategies, disease processes, data analysis, intervention processes field experience
- All Health Department staff should be trained in other respective collaborative disciplines. (For our work, this includes drug, alcohol and substance abuse as well as HIV/AIDS, STDs, Viral Hepatitis)
- Cross-training in HIV/STD/TB/Hepatitis/Substance Use

Specific Training Types/ Formats

- Develop integrated training modules and tools and offer them as TOTs and at regional meetings
- Assistance to the states/ local jurisdictions in providing CME and CEU credits for training attendees
- My understanding is that STD clinicians are most experienced in providing comprehensive care for STD screening, HIV testing, and vaccinations. Perhaps they can be a model to support comprehensive care in HIV testing settings and TB care settings.
- Training of Disease Intervention Specialists (DIS) staff
- Training of HIV Clinics on importance of TB testing for clients. Education for Clients on importance of knowing TB Status. Education of HIV positive clients to the avoid working in jobs or environments that put them at risk from TB.
- "Consultation visits" where key staff that have a successful integration, work with another area to develop the program in the new setting.
- Joint conferences should be held. The CDC annual meetings for TB, HIV, etc should be combined into one.
- Perhaps a one-time joint conference in Atlanta, which includes the Program Managers for all the programs involved for the purpose of networking and exploring the advantages and challenges of service coordination (and not integration).
- Peer technical assistance and provider education focus
- Health care worker hepatitis education initiative by the CDC. Assistance to the states/ local jurisdictions in providing CME and CEU credits for training attendees would be on the top of my priority list if we are going to adequately meet the training needs of HCWs.

Other Comments

- Cross training, communication, union issues, breaking down silos, development opportunities that are not time consuming or costly for states, more CDC onsite activity, or conversely creating funding for peer to peer TA onsite.
- Networking opportunities with colleagues that we need to integrate with. Better understanding of their needs and requirements; Better data collection tools to help demonstrate value and outcomes of prevention programs; Quality improvement tools; Speaker bureau PowerPoints for educational purposes focusing on different audiences (e.g., HIV, Health care workers, PCPs, community, those affected, included depression, treatment, prevention, risk factor and epidemiology information, liver wellness, what to do while waiting for treatment, testing, lab results and what they mean, vaccination, etc).

- Develop job descriptions that include collaborative/integrated responsibilities for some key federal staff (e.g., DIS). State and local health departments can also use it to develop their own job descriptions as needed.
- Need more staff. Local funds are diminishing, and we are left with fewer staff with more work responsibilities. Integration is another initiative that staff becomes responsible for.
- adequate funding
- Will need knowledge of the diseases we have not worked with in the past. Do not duplicate work. For instance if the number of HIV+ clients linked to care is reported by ADAP, don't have the STD Program report on that too.
- Need for systematic and comprehensive needs assessment, guidelines for implementation of opt-out HIV testing.

2. How can CDC best provide for the training/workforce development needs for PCSI?

Funding and Support

- Provide funding and technical assistance with curriculum development.
- Make funding available for training programs, unified guidance and training documents.
- Fund ongoing cross-training
- Provide assistance with CEU and CME access.
- Offer strategic planning resources to help programs to begin to integrate.
- Resources will need to be reprioritized to support training and TA regarding program integration.
- Topic specific regional training, with adequate funding provided in the COAGs. Enlist the cooperation of the RMTCCs in this effort.

Assessment

- If full-scale integration becomes the goal of programming, virtually all training/workforce development needs would have to be re-assessed.
- For now, CDC could further integrate other diseases such as HIV and viral hepatitis into ISTDI (Introduction to STD Intervention, the basic DIS training).
- Community provider level capacity to take on additional responsibilities must be assessed and supported. Appropriately trained staff may be required for some tasks (e.g. HIV secondary prevention interventions in the clinical settings); for other tasks relatively simple training and systems support will be adequate (e.g. screening and immunizations in the health care setting for HIV infected individuals). Careful consideration for these capacity needs for each integration task will be critical.
- Provide technical assistance to assess workforce skill
- Do the segregated (STD, HIV, TB) regional training centers ever communicate or meet?
  --Do they offer individual trainers and topics to be integrated into each others curriculum?
  --Do they share lists of training participants?
  --Do they include in course evaluations any suggestion for participants to expand their knowledge and seek cross training of other categorical diseases?
- Review of current patient and worker education products for HIV/TB to determine if there are gaps in education materials for workers and clients. Also coop with the RTMCC's, ATEC's and ALA's on delivering training.

Specific Types/ Modes of Training

- Provide other guidances and TA, this can include supporting training activities across jurisdictions. Perhaps this can become part of the scopes of service for NASTAD or other existing national entities.
- Customizable presentations including materials for various audiences (Chemical health, social work, corrections, etc) which AVHPC or other trained persons could access and

adjust to their needs. Would help ensure consistent messaging and provide a good base for new coordinators to start from.
- Webcasts, teleconferences, JOINT PO VISITS
- Interactive online teleconferences; Handouts and curriculum materials with evaluation tools and database to track outcome measures; Evaluation guidance documents and tools to implement; Electronic templates to help with program and prevention tracking (e.g., logic model templates, databases for evaluation of programs, tracking vaccination receipt, informed consents, referral mechanisms, screening tools, community testing day templates, etc.
- CDC can develop toolkits for integrating activities to assist in meeting training needs
- Develop local area trainers
- Training should be provided through the National prevention training centers for STD and HIV. These centers should include more training on TB and Hepatitis. TB and Hepatitis should be done through national centers.
- Include in NTCA workshop and other meetings programs attend in mass. Webcast?
- Continue disease specific training including cross training opportunities. Disease specific training should include how other disease processes impact outcome and how intervention for specific conditions can improve outcome
- Work with the regional centers to offer training courses.
- Work through/support for training centers

Suggestions for CDC

- Good question, yet I am not sure they have this capacity given our past experiences. So although I ask for onsite TA form CDC, I question their ability to deliver it and sustain any professional development over time.
- By setting a good example, project areas tend to emulate headquarters.
- Integrate at the CDC level. Effective communication between programs is key
- Make transparent how CDC PHAs are assigned and allocated both within programs and at locales.
- Historically, so many of the field staff working in HIV and TB came from STD. STD provide a foundation for worker move to another disease. I think we need to examine the investment CDC has in training, be it STD, HIV, TB training. And, then begin the process of developing a workforce that is capable of working across programs. This needed to be from the CDC administrative level down to the field. This will take some time but it will certain benefit communication and program operations.
- CDC could be of great assistance if they allowed for an offering of core collaborative trainings with which Health Department staff would be able/ required to attend.

Suggested Requirements/Actions

- Require in grants and provide adequate funding.
- Require formal linkages between training and education centers for TB and for HIV.
- develop common agenda for the AETCs and TB Regional Training centers
- Require increased collaboration with training centers for the various diseases at the regional level.
- Have a training program; require participation; develop certification activities; annual Continued Public Health Education standards; collaborate with/fund local schools of public health to offer such training

Guidance

- Have well-defined guidelines for integrated services and programs. Provide training on these guidelines to state and local programs
- There are well-integrated programs at the local level that CDC can work with in developing the guidelines and using as models.
- Unified guidance

Training of/for Specific Groups of Health Workers

- Provide technical assistance and training for Public Health Leaders and Emerging Leaders
- Work with Medical Schools to incorporate stronger public health and prevention topics in curriculum
- Cross-disciplinary consultation/training of program managers and administrators to facilitate state/local level planning for training and program implementation.

Other Comments

- Broaden definitions of integration to include other reproductive health and clinical prevention services. Bring together the US Prevention Services Task Force and Adolescent Health, School Health, MCH programs to design a new model of integrated public health program. Expand on the IPP model of bringing together FP and STD Programs.
- Update all training to included partner services.

3. What should states and local jurisdictions be doing in support of training and workforce development for PCSI?

Assessments

- Begin or continue internal assessments of PCSI and identify areas for enhanced PCSI.
- Organizing training, needs assessments to determine what type of training is needed and where, evaluation and follow up.
- Conduct assessment of all trainings in health departments to identify areas of PCSI.
- Incorporate PCSI in existing training
- States and locals should be identifying those in greatest needs for training including physicians, nurses, program managers, epidemiologists and DIS.
- States should coordinate collection of input from local health jurisdictions regarding
- needs assessments and current capacities in light of declining funding.

CDC Help/ Communications

- In our state, we have already had a fair amount of cross-training (HIV/HCV and HIV/STD in particular). We have regular meetings that include HIV, STD, Hepatitis and TB representatives to discuss fuller integration and these discussions include training and workforce development. Again, clearer direction on the use of currently categorical funding would be needed by health departments to prepare improve planning and program development.
- Support CDC through participation in curriculum development and prioritization of the process
- Can certainly institute training of staff if made clear what curriculum is desired.
- States should be distributing to the CDC information of lessons learned as a result of integration efforts. The information that is obtained by the CDC should in turn then be disseminated to all jurisdictions or made available through electronic access.

Specific State Support

- Allow for travel; Provide computers, phones, and equipment for teleconferencing; Instate travel; Equipment for educational programs; Support work with non-profits and professional organizations as fiduciary for educational programs; Support work with Pharmacy and health care organizations; Support web page design and resources; Information systems resources; Lab capacity and infrastructure for hepatitis testing; Work with health disparities and medically underserved.
- Provide opportunities for training
- Allow time for training.
- Identify staff that needs to be trained. Allow frontline staff time and approval to travel.
- Provide computer technology sufficient to support web-based training opportunities.

- Allow their employees to travel. In states with budget deficits this has been a real problem. CDC can alleviate this by requiring attendance at regional trainings in the COAGs and providing funding for this.

State Structure

- Discuss more collaboration projects.
- Having staff that are responsible for both HIV/STD/Hepatitis at the state and service provider levels. Encouraging integration of services at local level. Ensuring that core staff trainings include HIV, STD, Hep, etc, as well as general public health principles.
- Cross training, coordinating intervention activities e.g outreach, screenings
- Be involved in the process going on nationally to understand results expected. Begin discussions and planning with other local programs to integrate with to address where programs can begin to merge.
- Encourage programs to work together for the improvement of patient care. Provide the time for training employees on other disease processes and how patient outcomes improve when working together.

Specific Types/ Modes

- Work w/ prevention training centers
- On-site training courses.
- At least annual meetings of trainers from each regional center should meet and develop
- curriculum.
- There should be linkages of websites at all levels that encourage the cross training and access to information once trained.
- Insure Training for Local staff on assessing TB patients for risk factors to HIV and Hepatitis.

Cross-Training and Specific Topics

- Cross train and integrate all diseases into current training programs.
- Cross training is always important. Interviewing skills need to be strengthened, along with knowledge of transmission, pathogenesis, and risk assessment. However, disease specific knowledge experts should be maintained
- Having a staff trained on TB/HIV/Hepatitis/STD would provide a strong communicable disease base in states and local jurisdictions. These workers would also benefit from training in epidemiology, interviewing skill, human behavior skills and cultural competency.
- Cross-disciplinary training of front line staff and supervisors; supporting (and modeling) cross-disciplinary program planning and evaluation.

Other Comments

- Tough one. All state's vary in their ability and capacity to deliver a myriad of integration activities so what we do at our level fro training and development is an add on that we may not be willing/able to provide. I mean this does suggest another set of tasks and does not account for the notion of the variable I mention above; cross training, communication, union issues, etc.
- Directors from Immunizations, Epidemiology, HIV/AIDS, TB, STDs, and Viral Hepatitis need to collaborate to determine possible collaborative efforts. Directors from other programs, such as Dept. of Corrections, Alcohol and Drug Abuse, and Planned Parenthood clinics should be involved as well.
- Requesting technical assistance from partners like the ETC's and other organizations, collaborate within programs

Domain VI: Guidance/Guidelines

1. What specific guidance is needed by the field to support PCSI?

General

- Guidelines should not be mandated, but rather suggested
- A national roadmap including general principles, best practices, and recommendations may serve better than specific guidance unless CDC intends to be more directive in use of categorical funding.
- Guidance should start at the highest levels of CDC so that examples of collaboration should be occurring. Currently each section such as STD is so large that even within the program one part may not know about activities of another part. Examples are Syphilis azithromycin resistance testing, OASIS projects not being known by the project officer assigned to the State.
- Recommendations from CDC.
- Rationale, demonstration of effectiveness, articulation of evidence base
- Clarity in guidelines, policies, recommendations would be effective in communications between programs and providers. Not all areas of the various disease centered programs will be able to integrate completely. However, those areas where integration is possible should be integrated.
- How to set priorities and manage priorities for multiple diseases. In a general setting, at a local level, faced with limited resources and integrated, what determines the most important priority for the greatest benefit and for the long term?
- Need to have some kind of national education effort so people know what it is and can ask questions before I think you will have a real sense of what is needed in the field.
- Explanation of legal and HIPAA issues surrounding PCSI
- Ensure the relevant CDC program receive consistent communication.

Operational Guidance

- Operational guidance is most critically needed. There is a broad understanding and appreciation of why we should integrate, but there is a lack knowledge/awareness of specific models and strategies to facilitate this.
- Flexibility in guidance for program activities
- Clear and concise guidelines and expectations for integrated programs.
- Define integration, which programs?
- Flexible funding guidance designed to meet locally identified, data driven need
- Partner services
- There is a need for CDC to clearly define the difference between offering services to individuals that cannot afford or have access to private healthcare and individuals at highest risk for disease

Structural Guidance

- Guidance on where programs should be housed would be helpful for health department staff to better advocate for change.

Funding Announcements

- Funding announcements encouraging PCSI and samples of programs that work.

Technical Assistance/Training

- Fund ongoing cross-training
- Develop toolkits to provide local projects with ideas for integration activities
- Fund integration specialists to develop and report on integration projects in different jurisdictions.
- Develop a “Guidance of Best Practices” to support the process of integration in different settings.

- Dissemination of descriptions of model programs; Explain what is best practice and, if possible, back this up with evidence.
- Guidance on methods and models of how to collaborate and integrate services
- Provide technical assistance and training for Public Health Leaders and Emerging Leaders
- Develop integrated training modules and tools and offer them as TOTs and at regional meetings
- Publications and presentations at conferences to describe this work
- In general, Project Areas usual learn best from each other through peer-to-peer consultation. Identify successful programs and share their successes. Also, please take into consideration the variable resources available by Project Area for supporting PCSI.
- Focus groups that will bridge staff and programs in order to develop a culture of behavioral change regarding screening for communicable diseases
- Integration education and guidance for people other than the viral Hepatitis coordinators
- Sample assessment forms, Sample clinic protocols, Sample standing orders, and programs to train categorical staff how to perform counseling and testing services for different diseases
- Detailed information about how integration was successful in other areas. Simple updates on advances in the other disciplines

Other Comments

- Integration should be scrapped in favor of service cooperation. First, overcome the fears of CDC staff that this effort is likely to fail. Then, provide incentives for States to coordinate the services to their mutual clients. Forget mandating service integration.
- State staff needs to be honestly convinced that inter-program cooperation will benefit their programs and the clients they serve. History has often proven otherwise. Big dollar programs (e.g., HIV) have gobbled up the funds, and small programs (e.g. STD and TB) have diminished or even ceased to be. One has only to look at the incredible waste of money that has occurred in BT, often at the expense of other basic public health programs. If you forget history, you are doomed to repeat it. State governments all to often have re-directed funding away from original purposes (e.g. tobacco settlement funds) to meet other perceived needs. The pitfalls are many.
- This already happens in the field and at the local level on a regular basis. The public health nurse works with the "whole" patient and facilitates needed care or help with medical, mental health and social issues.
- What integration with guidelines already exists? Is there any at all?

2. What populations and/or venues are highest priorities for development of integrated guidelines?

General Comments

- Prioritization of epidemiologic data needs to be brought forth state by state to determine. This will give a local and national scene perspective that can be ordered and developed in both lights. For example, it may be important for us to nationally focus upon adolescents as a group that may benefit from the initial piloting of comprehensive screening both in primary care settings as well as in school clinics and other out of school venues. On the local scene, for example, MSM may be at incredibly high risk for multiple occurring issues like syphilis, HBV and HIV. Flexibility for a state to determine what and where they focus is important.
- Probably differs by area but in general, it would be reflective of client usage data showing overlap of service provision

Populations Identified

- MSM
- High risk heterosexuals
- Limited English proficiency Communities
- Injection Drug Users (past or present)
- Medically Underserved
- Uninsured Adults
- African Americans
- Incarcerated/re-entry
- Unvaccinated young Adults/ high risk adults
- Women
- Latinos
- Minority Populations
- Homeless
- HIV Positive
- Foreign Born
- Migrants
- Immigrant Populations
- Those least likely to return to clinic
- Those w/ Co-infections
- HCV positive who are not in care
- Sex Workers
- People who have difficulties accessing care other than public health offices/STD clinics
- Students

Venues Identified

- STD Clinics
- Drug & Alcohol Treatment Facilities
- Syringe Exchange Programs
- Prisons/ correctional settings
- Community Health Centers
- Emergency Departments
- Hospitals
- Local Health Department
- TB Clinics
- Alternative testing sites such as commercial sex establishments
- Public and Private HIV primary care and specialty care settings
- Mental Health Programs
- Immunization Clinics
- International Clinics
- Family Planning Sites
- Community-based Organizations/ Contractors
- Methadone Maintenance Programs
- Shooting Galleries
- Bars
- Technical Schools

Other

- Rural Areas
- The states who do not currently have integrated programs would be top priority. Programs serving populations at high risk for acute or chronic infection would be a priority, of course.
- Public Health Directors or State Medical Epidemiologists