Program Collaboration & Service Integration in CDC-Sponsored Training Courses

Long Beach, CA
June 24, 2008
Meeting Report

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Introduction & Background

This report presents the proceedings and results of the *Program Collaboration and Service Integration in CDC-Sponsored Training Courses* meeting that was held in Long Beach, California June 24, 2008. The attendees included approximately 30 leaders from NCHHSTP-funded training entities and CDC headquarters staff. The goal of the meeting was to develop a shared vision on integrated training opportunities for workforce development in program collaboration and service integration (PCSI). The primary outcome objective for the meeting was to obtain recommendations for future integrated training and identify 1) priorities for integration, 2) potential integrated courses and products, and 3) mechanisms to facilitate collaboration, implementation, and dissemination.

The impetus for the Training Courses meeting was the consensus opinion of NCHHSTP-funded partners attending the External Consultation on PCSI held in August 2007 (see http://www.cdc.gov/nchhstp/programintegration) that training and workforce development should be one of the three priority activities to be addressed by the Center over the next 3-5 years. The meeting described in this report was held to further define activities and roles for NCHHSTP and its funded partners specifically related to training and workforce development.

NCHHSTP Training Programs

There are four cooperative agreements that comprise a majority of NCHHSTP resources for training and workforce development.

1. The National Network of STD/HIV Prevention Training Centers (NNPTCs) are jointly funded by the Division of HIV/AIDS Prevention and the Division of STD Prevention. The NNPTCs are dedicated to increasing and maintaining the skills and knowledge of health professionals in the areas of sexual and reproductive health.

2. The Capacity Building Assistance (CBAs) services are funded by the Division of HIV/AIDS Prevention. The objective of the CBA funds is to increase the quality, quantity, and cost effectiveness of intervention activities and/or the sustainability of the supporting infrastructural systems.

3. The TB Regional Training and Medical Consultation Centers (RTMCCs) provide training and technical assistance to increase human resource development in TB programs.

4. The Viral Hepatitis Education and Training (VHET) providers develop, implement and evaluate education and training for health professionals, the general public, and groups at increased risk.

Training Integration Groundwork

In preparation for this meeting, training leaders from NCHHSTP Divisions developed two major products. First, a "course overview" packet was collated that describes the major on-going training provided by the funded training entities. The purpose of this information was to have a starting point from which training could be assessed for the feasibility and relevance of integrating disease areas and topics, and where integration already existed, be enhanced.

The second product consisted of a series of three tables that describe the disease area to one of three constructs:

- Table 1: Rational for Integration – presents the overlap in the disease areas in terms of risk behaviors, risk populations, and/or co-infection.

- Table 2: Interventions for Target Populations at Risk for HIV, STD, Viral Hepatitis, and TB – presents the overlap in the types of interventions between two disease areas.

- Table 3: Training Efforts Undertaken by NCHHSTP – describes training in each disease area that is available to segments of the workforce, e.g., clinicians, public health, community groups, and others.

Meeting Outcomes

The interactive portion of the meeting included 2 exercises: "strategic shift" and small group discussion. Several common themes emerged repeatedly, and are considered to be the most critical next steps for advancing PCSI in CDC-funded training.

1. **Present PCSI Introduction Slides at All Trainings.** Develop a short slide set (about 5 slides) to be included at the beginning of each training. A resource/referral slide should be developed and placed at the end of each training.

2. **Complete Review of Existing Curricula.** Begin with the work already completed prior to this meeting, and complete a review of existing training curricula. Develop and use a standardized methodology to determine the optimal degree of integration (awareness, knowledge, skill) for that training, make a determination as to if any of the content is addressing a public health core competency (e.g., contact tracing), identify if any of the content can be pulled as an integration module for use in other trainings (either because it addresses a fundamental aspect of a particular disease, or because it addresses a public health core competency). Within each curricula, add introductory slide on PCSI, add resource slide at end, and amend with integrated

content where possible (e.g., if the topic is sexual behavior, then should mention risk for STD and HIV, and sometimes hepatitis). Finally, it should be noted if additional research is needed to evaluate if validity of interventions is possibly being affected by alterations in training.

3. **Identify Core Competencies.** Two types of core competencies were discussed: 1) public health core competencies, such as contact tracing, and 2) core competencies for trainers who are delivering training on integration and integrated training. We need to answer the question "Who needs to know what?"

4. **Address PCSI in Needs Assessments.** Needs assessments should include PCSI-related items to better understand the emerging training needs of the field. As more jurisdictions and agencies begin to coordinate efforts and implement integrated services, training needs will emerge.

5. **Establish Regular Communication about PCSI between Training Entities and CDC.** Adding standing PCSI agenda item on regular conference calls and at meetings will offer an opportunity to alert others on upcoming events and opportunities, and will provide an avenue to discuss progress toward PCSI training goals.

Conclusions and Next Steps

The meeting produced many action steps that will be prioritized and addressed over the next several years. This report will be used as a basis for further discussion and prioritization within NCHHSTP in conversation with our funded training partners. The Center and Divisions are committed to moving forward on the recommendations made at the meeting.

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Introduction & Background

Introduction

This report is the proceedings and results of the *Program Collaboration and Service Integration in CDC-Sponsored Training Courses* meeting that was held in Long Beach, California on June 24, 2008. The attendees included approximately 30 leaders from NCHHSTP-funded training entities and CDC headquarters staff. The goal of the meeting was to develop a shared vision on integrated training opportunities for workforce development in program collaboration and service integration (PCSI).

The objectives for the meeting were to
1. Provide an orientation on PCSI
2. Learn about the various CDC funded training programs and areas of potential overlap
3. Identify opportunities and challenges in developing and implementing integrated training and education programs
4. Provide recommendations for future integrated training and identify
   a. priorities for integration
   b. potential integrated courses and products
   c. mechanisms to facilitate collaboration, implementation, and dissemination

The impetus for the Training Courses meeting was the consensus opinion of NCHHSTP-funded partners attending the External Consultation on PCSI held in August 2007 (see http://www.cdc.gov/nchhstp/programintegration) that training and workforce development should be one of the three priority activities to be addressed by the Center over the next 3-5 years.

Background

In 2007, the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (hereafter referred to as NCHHSTP or the National Center) set Program Collaboration and Service Integration (PCSI) as one of three cross-cutting programmatic imperatives. PCSI is focused on improving collaboration between programs in order to enhance integrated service delivery at the client level, or point of service delivery. The goal of PCSI is to provide holistic, evidence-based, comprehensive, and high quality prevention services to appropriate populations at every interaction with the health care system.

The National Center convened an External Consultation on Program Collaboration and Service Integration in Atlanta, Georgia, on August 21–22, 2007. The purpose of the consultation was to engage key NCHHSTP internal and external stakeholders in developing and refining the National Center's vision and objectives for PCSI and to plan

and prioritize PCSI activities over the next five years. Participants were asked to focus on confirming the framing of PCSI, identifying what CDC can do to assist local PCSI efforts, and identifying what CDC can do to improve its own efforts toward PCSI.

External consultants came to general consensus on three priority areas for NCHHSTP to focus efforts on for the next 3 to 5 years:
1. Integrated training
2. Integrated surveillance
3. Integrated funding

Related to training and workforce development, external consultants suggested NCHHSTP focus efforts on offering integrated training, as well as offering training on integration itself. Specifically, external consultants suggested these objectives:
- Increase workforce development and cross-training on NCHHSTP disease areas and prevention techniques for federal, state, and local public health staff
- Increase opportunities for shared training and education programs within NCHHSTP disease areas
- Develop and promote PCSI training and education to promote shared understanding and vision for state and local public health officials
- NCHHSTP OD and Divisions to provide training on PCSI for all Center project officers and program consultants

To achieve these objectives, the Center developed an action plan that included meeting with training leaders from the Divisions and holding an external consultation specifically on training and workforce development. Training leaders from the Divisions met for several months to plan the meeting and prepare materials that could support integrated training. This report includes the drafts of materials developed by the Division training leaders (Appendix J, K, L, M).

The meeting summarized in this report, *Program Collaboration and Service Integration in CDC-Sponsored Training Courses*, was one of the significant action steps toward integrated training, and training on integration. The Center will use the results of this meeting to guide future efforts in this area.

Overview of NCHHSTP Training Programs

This section describes the four cooperative agreements that comprise a majority of NCHHSTP resources for training and workforce development and provides a summary of the materials prepared for the meeting.

NCHHSTP Training Programs

I. *National Network of STD/HIV Prevention Training Centers* (NNPTCs)

The NNPTCs are jointly funded by the Divisions of HIV/AIDS Prevention and STD Prevention. The NNPTCs are dedicated to increasing and maintaining the skills and knowledge of health professionals in the areas of sexual and reproductive health. The goals of the NNPTCs are to

- Address the STD/HIV prevention training needs of public & private sector health professionals throughout the US, and
- Develop, deliver, & evaluate training activities on the diagnosis, treatment, and prevention of STDs & HIV.

Collaboration is included in NNPTC funding announcements, and the NNPTCs have been working collaboratively with the Division of Tuberculosis Elimination (DTBE) and with the training programs funded by other federal agencies including Substance Abuse Mental Health Services Administration (SAMHSA), Health Resources Service Administration (HRSA), and Office of Population Affairs (OPA) through the 4 training center workgroup. This group, commonly known as the "4TC" (or more recently "6TC" as other collaborators become involved), were chartered in 2002 by the Department of Health and Human Services (DHHS) to increase collaboration in overlapping focus areas and maximize the use of training resources. Activities of the 6TC include:

- Joint meetings and strategic planning (e.g., quadrant-wide advisory committees)
- Joint needs assessment of common training audiences
- Co-teaching of courses and educational activities

The NNPTC have several integrated curricula, including:

- Ask, Screen, Intervene (ASI), an integrated STD/HIV prevention curriculum to enhance prevention in HIV care settings
- Viral hepatitis prevention curricula
- Training on advancing HIV testing in medical care settings, including STD clinics
- Partnership for Health, a curriculum designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention
- Introduction to Integrated HIV/STD Partner Services, a curriculum based on the CDC Recommendations for HIV/STD Partner Services

The NNPTCs have three parts and each are described below.

Part I: Clinical and Laboratory Training
- 2-3 Centers in each geographic quadrant
  - Eastern Quadrant: MA, NY, & MD
  - Southern Quadrant: AL & FL
  - Central Quadrant: OH, MO, & CO
  - Western Quadrant: CA & WA
- Provide didactic & experiential training in STD diagnostics, treatment & management & HIV prevention
- Focus on clinicians in public & private practice

Part II: Behavioral Interventions Training
- 1 Center in each geographic quadrant
  - Eastern Quadrant: New York
  - Southern Quadrant: Texas
  - Central Quadrant: Colorado
  - Western Quadrant: California
- Provide training in effective behavioral interventions to decrease STD/HIV risk
- Focus on STD/HIV prevention specialists & prevention programs

Part III: Partner Services Training
- 1 Center in each geographic quadrant
  - Eastern Quadrant: New York
  - Southern Quadrant: Texas
  - Central Quadrant: Colorado
  - Western Quadrant: California
- Provide training in STD/HIV interviewing, counseling & referral for patients & partners
- Focus on public health workers in STD/HIV programs

II. *Capacity Building Assistance Services* (CBAs)

The Divisions of HIV/AIDS Prevention supports the Capacity Building Assistance (CBA) training cooperative agreement, which is intended to increase the quality, quantity, and cost effectiveness of intervention activities and/or the sustainability of the supporting infrastructural systems. The goals are to improve the delivery or effectiveness of
- HIV prevention services for racial/ethnic minority populations and prevention projects for community-based organizations.
- HIV Prevention Interventions for high-risk racial/ethnic minority subpopulations.

There are two components of the CBA program:
1. Training on HIV Effective Behavioral Interventions (DEBIs)
   - Popular Opinion Leaders (POL), Safety Counts, SISTA, Street Smart, VOICES/VOCÉS

- Focus on Youth + IMPACT
- Social Networks Strategy
- Modelo de Intervention Psycomedica (MIP)

2. Training on HIV Prevention Strategies
   - The Training and Development Team provides training on HIV prevention strategies (13 trainers)
   - Primary subject is Counseling, Testing and Referral services (CTR)

III. *The TB Regional Training and Medical Consultation Centers* (RTMCCs)

The purpose of the RTMCCs is to provide training and technical assistance to increase human resource development in TB programs. The RTMCCs develop and distribute TB educational materials and provide medical consultation to TB programs and medical providers. Education and training comprise about 80% of the work of the RTMCCs, with medical consultation comprising the rest. Topics and types of training are primarily determined by needs assessments.

The RTMCC refocused in 2005 to become 4 regional centers. TB RTMCCs are regionally assigned to cover all 50 states and the U.S. territories through the four funded centers:
- New Jersey Medical School Global TB Institute (NJMS GTBI), Newark, NJ
- Southeastern National TB Center (SNTC), Gainesville, FL
- Heartland National TB Center (HNTC), San Antonio, TX
- Francis J. Curry National TB Center (CNTC), San Francisco, CA

## IV. *The Viral Hepatitis Education and Training* (VHET)

The Goal of the Viral Hepatitis Education and Training cooperative agreement is to develop, implement and evaluate education and training for health professionals, the general public, and groups at increased risk. Twelve diverse organizations and projects were funded, project focus ranged from training health professionals to public education campaigns and initiatives. This is the final year of the 3 to 5 year funding cycle.

A new funding announcement is currently being advertised, with awards determined by September 2008. The goals of the new announcement are to increase integration of viral hepatitis prevention services into other services, and to increase health professionals' abilities and skills, e.g., risk assessment. There are four parts under the new announcement:
   A. Networking, Partnerships
   B. Implementation of Health Education Programs
   C. Diffusion of Effective Health Education Programs
   D. Training

Training Integration Groundwork

As described earlier, participants of the August 2007 consultation on PCSI named "training integration" as one of the top three priority focus areas to be addressed over the next 3-5 years. The external consultants called for both offering more *integrated training*, and for *training on integration*. Using these suggestions as a platform, training leaders from the Divisions met for several months to prepare for the meeting described in this report. In preparation for the meeting, several supportive documents were developed (Appendix J, K, L, M).
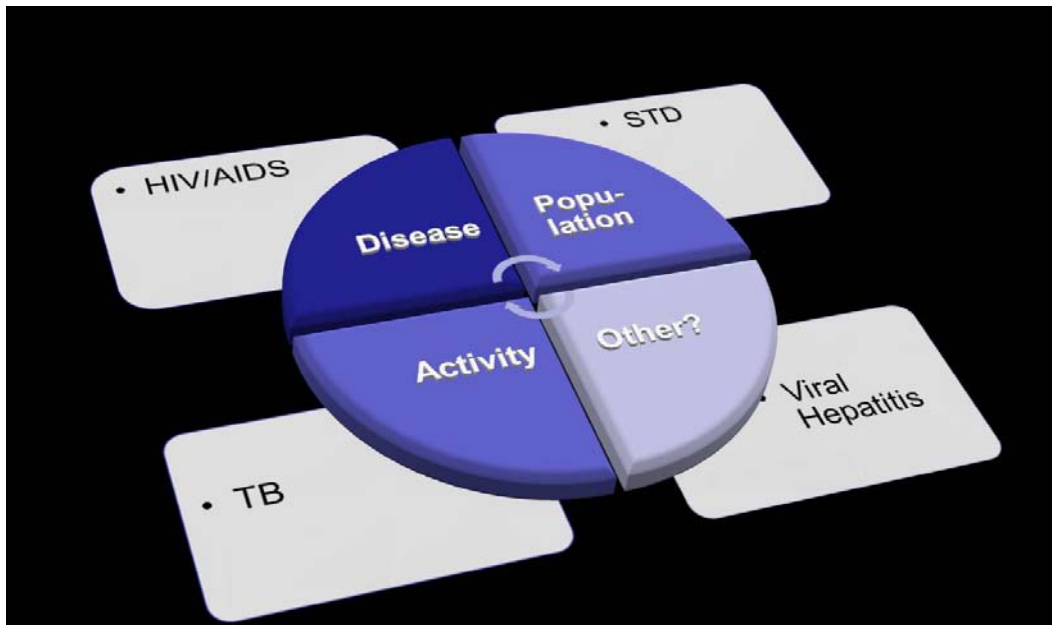
In preparation for this meeting, training leaders from NCHHSTP Divisions developed two major products. A "course overview" packet was collated that describes the major on-going training provided by the funded training entities. The purpose of this information was to have a starting point from which training could be assessed for the feasibility and relevance of integrating other disease areas and topics, and where integration already exists, where it can be enhanced.

The second major product was a set of three tables describing the disease area to one of three constructs:
1. Table 1: Rational for Integration – presents the overlap in the disease areas in terms of risk behaviors, risk populations, and/or co-infection.
2. Table 2: Interventions for Target Populations at Risk for HIV, STD, Viral Hepatitis, and TB – presents the overlap in the types of interventions between two disease areas.
3. Table 3: Training Efforts Undertaken by NCHHSTP – describes training in each disease area that is available to segments of the workforce: clinicians, public health, community groups, and others.

Proceedings: Small Group Activities

The interactive portion of the meeting included 2 exercises: "strategic shift" and small group discussion. The purpose of the "strategic shift" exercise (presented first below) was to get participants to begin thinking about possibilities for training integration and sharing ideas. The second exercise was more focused, with three small groups discussing program integration from the perspective of one of the following audiences: 1) public health workforce, 2) clinicians, and 3) community.

Group Process I: "Strategic Shift"

The first group process was the "strategic shift" exercise. The purpose of the exercise was to get participants thinking about possibilities for training integration and to begin identifying opportunities, barriers, and solutions. Participants divided into three groups to brainstorm answers to the question, "How can we promote service integration into current training?" They noted their answers on flip-chart paper. Each group rotated and reviewed the previous groups' ideas, picking one idea from the list as the focus strategy. Using the focus strategy, the group listed action steps required to accomplish the strategy. After a few minutes, the groups shifted again to review the previous group's work; they listed barriers to the action steps written by the previous group. The groups shifted again, reviewed the previous group's work, and created a list of solutions to the written barriers. The results of this exercise are presented in Table 1.

The common themes in the brainstorming portion of the exercise, in response to the question "How can we promote service integration into current trainings" included:
- Expand training target audience to accommodate PCSI, e.g., cross training
- Integrate relevant curriculum material into courses and training
- Collaborate with training experts from other disease and specialty areas
- Provide "fundamentals" courses, or develop discrete training modules on:
  - prevention and control for all disease areas (by population, audience, or skill)
  - other "core competency" areas for public health
- Providing a message about PCSI at the beginning and/or end of each training, also at national, regional, and local conferences, workshops, and meetings, e.g., Ryan White and Regional Prevention group meetings
- Incorporate PCSI goals and rationale in marketing materials for training and conferences
- Highlight links to other disease-area training partners, including contact information, with an emphasis on local-regional contacts
- Provide point-of-care or experiential training
- On-line training

Two of the three groups focused on the same strategy, that of integrating other disease areas into existing curricula. The third group focused on "experiential" or point-of-care training.

Table 1. Results of "Strategic Shift" Exercise

Selected Activity I & II Integrating Other Disease Areas into Existing Curricula	Selected Activity III Point-of-care or Experiential Training
Action Steps	**Action Steps**

• Inventory and cross-program review of existing curricula
  – Define "integratable" content
  – What level of detail is needed?
  – Which audience needs what level of detail?
• Assess capacity building needs and readiness
• Assess integration training needs of providers
• Analyze curriculum and identify gaps and opportunities, identify existing modules and materials to fill gaps
• Develop modules, or modify to incorporate information to enhance integration of services
• Include rational for integration
• Include resources for linkage to services
	• On-site Training at Clinics
	• Identify those at greatest need for service
	• Procuring / developing of mobile training force with RTG training toolkit
	• Identify additional funding
	• Peer-to-peer strategy (capacity building)
	• Sustainability via TA/ consult

Barriers	**Barriers**

• Personnel & Organizational
  – staff time to devote to inventory, production and adaptation
  – Need to be cross-trained on other diseases, (to level of being expert, and need comfort with material to communicate to next audience
  – Organizational capacity / readiness
• Minimal level of standardization
• Clearance process
• Competing priorities
• Not enough time within training courses
• Shifting and expansion of focus and priorities
• Who takes the lead?
• Developing workforce on PCSI while editing and rewrite curricula
• Top-centered process thus far (where is workforce buy-in?)
• Epi data may not support PCSI
	• Low perceived need by providers
	• Competing priorities at service-level
	• Resources-- time and money (both for trainers & provider)
	• How to prioritize sites?
	• Work culture and geographic differences
	• All levels of staff at agency buy-in
	• Multidisciplinary teams needed (how do you develop & fund-multi funding streams)
	• Onsite distraction/issues
	• Unfunded mandates- staff shortages and increased responsibility
	• Experimental (requires pre-assessment of site)
	• Client privacy issues and distraction for providing them care

Solutions	**Solutions**
• Incentives to participate in assessments • Standardize, shaped partnership of work load • Reduce existing training expectations • Rely on (utilize) regional experts • Develop and/or strengthen regional training teams (of integration experts)	• Need to market and create buy-in for integration • Consultations • Successful piloting • Regional approach

Selected Activity I & II Integrating Other Disease Areas into Existing Curricula	Selected Activity III Point-of-care or Experiential Training
• CDC (and other funding sources, define integration activities as deliverables (and fund!) • Provide trainers with modules (that are flexible to PTC/CBA / AET/6 TC etc… • Develop public health core competences in disease area cluster (HIV, STD, TB, viral hepatitis) • May have to expand training time • Focus on populations most at risk for Specific Disease • Buy-in buying devoted staff time to integration of information • Internal TOT on integrated curriculum models on HHST (face to face or web based)	• Public health basics • Understand audience -- Multi-level training – Managers and Front line • Better define readiness • Identify champions • Build reinforcement for staff into training • Plan for follow-up/ ongoing

Group Process II: Small Group Discussion

The second exercise was small group discussion on training for three audiences: 1) public health workforce, 2) clinicians, and 3) community. Participants were asked to discuss these questions:

1. What current collaboration and integration is taking place?
2. When does it make sense to integrate training? (How do you determine if a course/product should be integrated? Is there an algorithm for making this determination?)
3. To what degree should integration take place? (What kind of content and how much content should be integrated into existing courses and products. In the course inventory we identify three types of content - referrals, delivery of services, health messages - is this the most useful way to think about the degree to which integration should takes place?)
4. What would a module on PCSI contain for all NCHHSTP training?
5. What steps are needed to integrate training?
6. What resources are needed to integrate training?

A summary of the discussion from each of the small groups is presented below.

Clinicians

1. What current collaboration and integration is taking place?
There are varying levels of integration. Some clinicians take care of groups who are co-infected and are charged with taking care of all the needs of a patient, e.g., correctional care, boarder health/migrant health, community health centers, Indian health, rural health. These clinicians don't need to be persuaded to integrate. There

are clinicians who are experts in a single focus area who are seeing co-infected populations, but some are reluctant to add additional services or change their practice. For this set, there should be more of a sell on integration.

There are some methodological areas of expertise ("core competencies"), such as contact tracing or assisting with adherence to medical treatment that are common across disease focus areas.

Suggestions
- Provide "Setting the Scene" overview on integration at onset of training
- In addition to standard fare course offerings, some training has been developed for providers (i.e. rural health, correctional, refugee) who already need a more holistic approach
- Webinar on public health collaboration
- "Asilomar" – Skills building and faculty development for trainers conference
  o integrated format, using case study/skill development
  o supporting faculty to get integrated skills, not just disease content
- Border health other population-based training

2. **When does it make sense to integrate training? (How do you determine if a course/product should be integrated? Is there an algorithm for making this determination?)**
   It makes sense to integrate training for clinicians in the following circumstances:
   - The topic is disease specific, or on a specific population served
   - Expertise in key methodologies are needed across disciplines (contact elicitation, adherence)
   - There is one training entity that has an "in" with a group (e.g., TB and corrections), and then use these connections to get integrated messages to the clinicians
   - When training on co-infected and vulnerable populations

   Suggestions
   - Develop resource slide for other diseases to incorporate into training
   - Need a commitment from each training entity to review course by course to determine where incorporating/integrating would make the most sense using levels of integration. Need to review each course to determine what is the most important to integrate or need to look at the population to be addressed in a particular training.

3. **To what degree should integration take place?**
   The group conceptualized the degree of integration in three levels:

   Level 1: Information
   At this level, information would be provided at all training courses on the rationale and context for PCSI. It was suggested that an overview on PCSI (approximately 5

slides) be provided at the beginning of all training courses, and a resource/referral slide for additional information be at the end.

Level II: Knowledge

For some audiences (e.g., correctional health), content on other diseases would be provided in a one-day overview training course. Subject matter experts would present on disease.

Level III: Skills Building

This level would include Level II or a content module, plus an experiential learning activity. This type of training would be a jointly planned and delivered training (expert faculty members come together to design training on a topic – for example TB and STD before and then actually deliver training)

Suggestions

Develop introductory slide set that describes the rationale for PCSI, the reasons why it's important, and how it relates to the audience and their work. Remind audience about rationale, identify trends, epi data that are current issues.

4. **What would a module on PCSI contain for all NCHHSTP training?**

The group felt that a PCSI module would not be appropriate for most clinicians, rather they suggested "branding" all training with PCSI information at the beginning and end (as suggested above, Level I). The group noted that it will be particularly useful to have resource lists and materials for clinicians to help them integrate when possible.

The group highlighted the need to be clear whether and when we're talking about <u>training on integration</u> or <u>integrated training.</u> Clinicians may need training on integrated prevention techniques (agree that clinicians are missing opportunities, for example, testing HIV+ for STD and vise versa). There may also be a need for skills training (e.g, genital exam and rectal exam) and this is based on priorities we set.

Suggestions
- CDC guidance should include prevention for other diseases, for example, there could be recommendations for clinical care of HIV infected persons that would address the other disease areas
- It was noted that HRSA training also do not focus on integrated treatment, and there is a need to access to HRSA training

5. **What steps are needed to integrate training?**

The group suggested several ideas, primarily involving keeping integration activities on the radar and other communication activities.
- Reward, encouragement, recognition needed for more flexible offering of training for particular populations, e.g., Maine has large immigrant population which would involve TB
- Consider what evaluations and needs assessment show that could be beneficial for the other diseases/Divisions training entities

- Communication among training entities – how to be aware that something coming up is of interest to the other PTCs
- Have a portion of each monthly or quarterly call among training entities to identify something of interest across each Division
- Identify a person within each Training entity to be on the conference call to let others know of upcoming events of interest
- TB educator and training meeting, poster session

6. What resources are needed to integrate training?
- Funding and Resources - Resources can be different for the 3 levels
- Time
- Faculty support – need to pay doctors and nurses to develop and give training.

Suggestions
Consider video conferences to save travel dollars, use the funds to develop new training and support faculty.

Community

1. What current collaboration and integration is taking place?
The group discussed the current collaboration at national and regional levels between the training entities (Capacity Building Assistance, the "6TC" partners), and for specific interventions (DEBI's). DEBIs are good example of collaboration and integration. Specifically noted:
  - VOICES / VOICES (HIV/STD), Street Smart (HIV/STD),
  - RESPECT (STD/HIV), Safe in the city (STD/HIV), Community Promise (STD/HIV), Partnerships for Health (STD/HIV), CLEAR (STD/HIV),
  - Safety Counts (HIV/HEP), 3MV (STD/HIV/HEP),

Suggestions
Examine what are the intervention targets, what is it intended to do, and then discuss what could/should be integrated

2. When does it make sense to integrate training? (How do you determine if a course/product should be integrated? Is there an algorithm for making this determination?)
The group generally agreed that it makes sense to integrate when integration matches the needs of the target audience. The group made the point that program integration leads to need for integrated training, but training will not lead to integration. The group stressed a need for leadership to identify and communicate clear integrated programmatic priorities, to which training will be geared.

The group stressed the need to examine existing programs and develop PCSI "core competencies" – and to specifically look at TB since this disease is the least integrated thus far. The group stressed the importance of maintaining fidelity to

evidence-based interventions when integration is being considered, and suggested that integration priorities are backed by evaluation/research that demonstrates efficacy. Finally, the group advised conducting needs assessments of target audiences prior to developing training, and to lay groundwork to foster a readiness to change (from a silo'ed to an integrated mindset) if needed.

Suggestions
o Begin with identifying PCSI core competencies – what are they?
o Must train trainers on PCSI core competencies
o Need to craft messages to guide and change behavior that work
o Need to determine what we want people to do differently and identify available resources
o Integrate DEBIs when it doesn't compromise or compete with fidelity – we need research and evaluation
o Need to look specifically at how/when to include TB
o Highlight where integration also exists as a first step Highlighting pieces that already exist in current DEBIs
o Need to leverage advocacy for PCSI

3. **To what degree should integration take place?**
   The group developed a list of issues to consider around the degree of integration:
   - Change occurs in incremental steps – begin with promoting the rationale to change the culture of trainers and community groups (get buy-in)
   - Develop curriculum on PCSI guidelines and diffuse it, and provide training to support PCSI goals
   - CDC should develop FOA's to support PCSI, and then build training system that supports the FOA
   - CDC should identify where integration takes place in a training strategy / intervention. For example – in a DEBI training when you are talking about a risk behavior for HIV, can add other diseases as appropriate without taking away from training/interventions. Be sure to review curriculum – identify where changes are needed; be sure to not give contradictory messages.
   - Need experiential activities to support PCSI
   - Look for opportunities to incorporate PCSI information into training (message oriented strategy).
   - When conducting training, pinpoint key opportunities to tell them when risks over-lap.
   - Train on how risk behaviors can lead to more than one disease
   - Focus on addressing perception of risk… show organization how diseases are related to each other… and change how clients view their risk

4. **What would a module on PCSI contain for all NCHHSTP training?**
   - Rationale for PCSI (show how lack of PCSI results in health disparities in service delivery, for example)
   - Public health 101 and universal concepts regarding infectious diseases, for example (exposure by dose and time)

- Practical application of knowledge and experiential activities → need AHA! Moments
- Rates/prevalence/incidence
- Theoretical integration (DEBIs)

5. **What steps are needed to integrate training?**
   - Conduct curriculum inventory for gaps and opportunities
   - Identify PCSI activities as deliverables for funding in training grants (deliverables)
   - Guidance on behavioral goals, long term effects (long term accessing preventive services, behavioral goals might also include increasing health promotion behaviors such as seeking of services)
   - Developing core competencies around integration and public health
   - Develop core competency for PCSI for trainers – what do they need to know to train others?
   - Develop CDC guidelines on PCSI in a collaborative way
   - Cross train trainers in different disease areas
   - Ask organizations to revise or suggest revisions to their own training, and give others opportunities to review and suggest revisions on existing training

6. **What resources are needed to integrate training?**
   - Funding
   - Expertise
   - Need to prepare trainers to train on PCSI effectively
   - Strategy for review and making changes to curricula
   - Phased approach – imbedding messages; then experiential approach
   - Time to devote to integration activities
   - Suggest using Good, better, best – resources for our trainers & providers – what they need to know about each disease
     - Good – delivering messages
     - Better – building public health competencies
     - Best – enhancing skills
   - CDC/Division support for PCSI (DHAP/DSTDP) Need attitudinal change
   - For some DEBIs – rationale module – why it's important
   - Evaluation and follow-up -- what happens as a result of training?

Public Health Workers

Define public health work force: People who work in state and local HD, including front line workers but not necessarily clinicians.

1. **What current collaboration and integration is taking place?**
   The group agreed that local public health workers are often jack-of-all-trades who are working on several different disease areas, under many funding streams. As you go

up to the state and federal level the work becomes more disease-specific and perhaps entrenched. The group also noted current levels of collaboration and integration seem to vary by disease (more HIV and STD integration than TB and viral hepatitis), and from state to state. For example, in places where the HIV epidemic is driven by substance abuse, there is more overlap with viral hepatitis. It was noted that Public Health Workers need various training based on local epidemic characteristics, and by type of venue.

2. **When does it make sense to integrate training? (How do you determine if a course/product should be integrated? Is there an algorithm for making this determination?)**
The group suggested that the decision to integrate should include a review of the local epidemiology, and would be determined by the population served and venue. The group suggested identifying skills that are common across disease areas -- the fundamentals of public health and specifics for our cluster of diseases (e.g., field safety, disease investigation, screening, adherence) and train on these.

3. **To what degree should integration take place?**
   - Training content should be shared, and when integration isn't possible refer to other trainers
   - Offer cross training, e.g., send TB workers to HIV training. Would need agreements to share resources
   - Some parts of existing courses can be taken and put into other training – example, some DEBIs have great behavior change modules that can be placed into other training
   - Need to take time to review and find the important pieces that can used more universally –need a list of top priorities that should be looked for from other training
   - Need to have experts in a disease area to give recommendations to the primary content person on where and to what level the additional disease should be placed.
   - Identify where there are blocks of information that might be good as "core competencies" that would be available for all diseases
   - Training on population specific information AND approaches… e.g., substance abusing, homeless, migrant populations… akin to cultural competency
   - Need a way to prioritize what diseases and training should be used when and where, and to what level, e.g., awareness, knowledge, expert… this might be dictated by the person's job/role

4. **What would a module on PCSI contain for all NCHHSTP training?**
   - Definition, roles/responsibilities, rationale, epidemiological overlap, importance to client
   - Acknowledge that work has been done (look at best practice, describe effort to formalize, standardize, and support)
   - Acknowledge barriers, limitations (it is not for all people at all times – think about where greatest opportunities are)

- Address fiscal questions (this will vary depending on audience – program managers could be shown how this makes sense fiscally, health department may need training on funding parameters)
- Provide resource list
- Clear expectations on what integration should be done
- Core skills, competencies, don't dilute too much, develop lean and mean training

Suggestions
- Identify what people are expected to know (core competency), and communicate how they can come to know it (cross training or integrated training)
- Clear expectations and requirements for training
- Need resources such as a list of partners and stakeholders, this list of people and key contacts in programs, states, regions – needs to be a living document
- Need training system to be flexible enough to allow for places that won't integrate (need to realize how some state health departments are structured)
- Trainers should consider conducting a local policy assessment that could help know your regions and help to develop the appropriate training

5. **What steps are needed to integrate training?**
   - Identify strategy for how to approach states. Each locale and state have their own policies and customs. Review previous needs assessments and identify barriers and bridges, key personnel. Training centers know their audience. Share information on disease by region, so that appropriate integrated training can be developed.
   - Provide guidance – input for everyone on what is expected, 1) practical guidance via coop agreement objectives for example, 2) involve stakeholders in the process, 3) objectives that are disease specific in FOAs
   - Define levels for specific audience – core competencies for specific audience (on same topic area: DIS should know what? Docs should know what?)
   - Consider incremental plan for role out – identify when additional related topics (e.g., mental health), will be added
   - Be sure that the addition is something of value before you "break" existing system
   - Look to future needs to start – what is important coming down the pike to start with
   - Evaluate efforts and assess if what was done worked

6. **What resources are needed to integrate training?**
   The group identified funding, personnel and experts, and time as the main resources needed, and also suggested:
   - Develop a reference list of key personnel on programs, states, region (needs to be a living doc on CDC website)
   - What is expected, guidance, recommendations – what does CDC recommend that workers in the field should DO (then the trainers will train on this), and perhaps tied to funding directives (e.g., objectives in program announcements)
   - Examples of integration/models

- Regular meetings of this group (or similar) to continually review and update. Each perspective is important.
- Evaluation of integration – what did we do and did it work
- Marketing – get PCSI on radar at many levels

Meeting Outcomes

The primary outcome objective for the meeting was to obtain recommendations for future integrated training and identify 1) priorities for integration, 2) potential integrated courses and products, and 3) mechanisms to facilitate collaboration, implementation, and dissemination. The meeting structure did not include a formal prioritization process, however, there were a few points that clearly emerged from within each of the small groups independently, and these points were confirmed as important action priorities during the large group discussion:

1. Develop a short slide set (about 5 slides) to be included at the beginning of every training, and a relevant resource or referral list at the end
2. Complete the review of existing curriculum
3. Identify core competencies for (1) master trainers who are training on PCSI or providing integrated training, and (2) public health professionals more generally
4. Address PCSI in needs assessments
5. Establish PCSI as a standing agenda item on training conference calls

These priorities fall into the categories of potential integrated courses (i.e., short introductory slide set on PCSI) and mechanisms for communication (i.e., PCSI as standing agenda item), but also outside of them (i.e., core competencies, needs assessments). These five items emerged nearly universally from within the breakout groups for clinicians, public health workforce, and community, and were the strongest of all themes. Therefore, these five items will be prioritized first as action items.

Beyond these five themes however, there were many other threads and ideas that ran through the day that are worth highlighting. The summary below provides more detail from the day's rich discussion, fleshing out the top 5 priorities and summarizing additional threads and themes.

General Themes

Curriculum Review
- Complete the curriculum inventory to identify gaps and opportunities for integration. There should be a methodology developed to standardize the review.
- Identify a way to prioritize what diseases and training courses should be used when and where, and to what level (e.g., awareness, knowledge, skills). This might be dictated by the audience or the purpose of the training.
- Utilize experts in each disease area who would provide recommendations to the primary content person on where, and to what level, the additional disease content should be placed.

- Identify where there are blocks of information that might be good as "core competencies" that would be available for all diseases. Develop a list of top priorities that should be looked for among the other training courses.

Core Competencies
- Identify core public health competencies for each disease area
- Identifying core competencies for skills that are common across disease areas (e.g., field safety, disease investigation, screening, adherence) and train on these.

Training of Trainers & Faculty Development
- Develop core competency for PCSI for trainers – what do they need to know to train others?
- Provide training for trainers on integration
- Provide support for faculty – need to pay doctors and nurses to develop and provide training

Evaluation, Assessment, and Research
- Conduct needs assessments of target audiences prior to developing training, and to lay groundwork to foster a readiness to change (from a silo'ed to an integrated mindset) if needed.
- Consider what evaluations and needs assessment show that could be beneficial for the other diseases/Divisions training entities.
- Provide guidance on behavioral goals, long term effects (long term accessing preventive services, behavioral goals might also include increasing health promotion behaviors such as seeking services).
- Maintain fidelity to evidence-based interventions when integration is being considered, and suggested that integration priorities are backed by evaluation/research that demonstrates efficacy.

Working with Training Audiences
- Trainers should consider conducting a local policy assessment that could help know your regions and help to develop the appropriate training.
- There is a need to be aware that some training audiences and management structures may not support integration, and there is a need to lay additional groundwork to garner support for PCSI before training can be effective.
- Identify strategy for how to approach states. Each local and state have own policies and customs.
- Need training system to be flexible enough to allow for places that won't integrate (need to realize how some state health departments are structured)

Cross Training
- Identify ways to facilitate greater latitude and permission for cross training (e.g, STD workers access to TB training).
- Ensure CDC headquarter staff support these efforts.
- Develop agreements to share training resources across programs

- Provide rewards, encouragement, recognition needed for more flexible offering of training for particular populations, e.g., e.g. Maine has large immigrant population which would involve TB.

Funding
- Identify PCSI activities as deliverables for funding in training grants (deliverables)
- Identify how training system can support programmatic activities funded by CDC

Guidelines
- Develop curriculum on PCSI guidelines and diffuse it, and provide training to support PCSI goals.
- Develop integrated CDC guidance that includes prevention recommendations for other diseases, for example, there could be recommendations for clinical care of HIV infected persons that would address the other disease areas.
- Provide guidance on behavioral goals, long term effects (long term accessing preventive services, behavioral goals might also include increasing health promotion behaviors such as seeking services)

Themes on Integrated Courses and Products

Participants agreed that an immediate next step is to develop a brief slide set on PCSI (approximately 5 slides) to be included at the beginning and at the end of every training. This activity was seen as a realistic, immediate, and important step for increasing general awareness and beginning to lay the foundation for more substantive integration of curricula in the future.

Suggested Process or Conceptual Framework for Adapting Training
The group suggested that CDC consider conceptualizing the degree to which integration is attained in any given curricula by three levels: awareness, knowledge, skills.

Level 1: Information
At this level, information would be provided at all training courses on the rationale and context for PCSI. It was suggested that an overview on PCSI (approximately 5 slides) is provided at the beginning of all training courses, and a resource/referral slide is provided at the end.
- Develop introductory slide set that describes PCSI, the reasons why it's important, and how it relates to the audience and their work. Remind audience about rationale, identify trends, epi data that are current issues.
- Develop resource slide for other diseases, where trainees can go for more in-depth information on a topic

Level II: Knowledge

For some audiences (e.g., correctional health), content on other diseases would be provided in a one-day overview training course. Subject matter experts would present on their disease.

- Rationale for PCSI (show how lack of PCSI results in health disparities in service delivery, for example)
- Public health 101 and universal concepts regarding infectious diseases, for example (exposure by dose and time)
- Practical application of knowledge and experiential activities → need AHA! moments
- Rates/prevalence/incidence
- Address fiscal questions (this will vary depending on audience – program managers could be shown how this makes sense fiscally, health department may need training on funding parameters)

Level III: Skills Building

This level would include Level II or a content module, plus an experiential learning activity. This type of training would be a jointly planned and delivered training (expert faculty members come together to design training on a topic – for example TB and STD before and then actually deliver training)

- "Asilomar" - Skills building and faculty development for trainers conference
    - integrated format, using case study/skill development
    - supporting faculty to get integrated skills, not just disease content

Themes on Collaboration, Implementation, and Dissemination

Communications

- Develop communication networks among training entities to provide alerts on upcoming PCSI events.
- Have a portion of each monthly or quarterly call to identify something of interest across each Division.
- Identify a person within each Training entity to be on the conference call to let others know of upcoming events of interest.
- Develop resources such as a list of partners and stakeholders, this list of people and key contacts in programs, states, regions – needs to be a living document
- Provide a Webinar on public health collaboration

Sharing Information & Dissemination

- Identify a non-CDC web space to serve as a central location for sharing training modules. Training modules should be available to review and accessible for use from the site.
- Consider how to merge this group as part of 6TCs.

Process for Collaboration

- Establish a commitment from each training entity to review course by course to determine where incorporating/integrating would make the most sense. Levels of integration would make sense – Need to review each course to determine what is the most important to integrate or need to look at the population to be addressed in a particular training.
- Master trainers to review curricula to see where integration could take place. Possible to have external review to obtain a fresh perspective. Also review with expertise in disease area so that accurate info is included.
- Need to have experts in disease area to give recommendations to the primary content person on where and to what level the additional disease should be placed.
- Ask organizations to revise or suggest revisions to their own training, and give others opportunities to review and suggest revisions on existing training
- Engage state/local partners in development of training and guidance. We already know they want it and they have problems because of lack of PCSI. Except maybe in the community where it seems like a possible loss of resources.
- Identify strategy for how to approach states. There is a need to be aware that some training audiences and management structures may not support integration, and there is a need to lay additional groundwork to garner support for PCSI before training can be effective. Need training system to be flexible enough to allow for places that won't integrate (need to realize how some state health departments are structured).
- Trainers should consider conducting a local policy assessment that could help know your regions and help to develop the appropriate training
- Each local and state have own policies and customs. Review previous needs assessments and id barriers and bridges, key personnel. Training centers know their audience. Share info on disease by region, so that appropriate integrated training can be developed.
- Identify and utilize any training entity that has an "in" with a group (e.g., TB and corrections), and then use these connections to get integrated messages to the clinicians

General Suggestions, Recommendations, and Ideas

The meeting participants made these general comments, suggestions, and requests.

- Be clear whether and when we're talking about <u>training on integration</u> or <u>integrated training.</u>
- There is a need to keep some depth/expertise on specific diseases.
- Be sure that the addition is something of value before you "break" existing system
- Look to future needs to start – what is important coming down the pike to start with
- The point was made that program integration will lead to a need for integrated training, but training alone will not lead to integration. First, programmatic priorities should be identified and clearly communicated, and then training can be used to support programmatic objectives.

- What is expected, guidance, recommendations – what does CDC recommend that workers in the field should DO (then the trainers will train on this), and perhaps tied to funding directives (e.g., objectives in program announcements)

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Conclusions

The primary outcome objective for the meeting was to obtain recommendations for future integrated training and identify 1) priorities for integration, 2) potential integrated courses and products, and 3) mechanisms to facilitate collaboration, implementation, and dissemination. The meeting structure did not include a formal prioritization process, however, there were a few points that clearly emerged from within each of the small groups independently, and these points were confirmed as important action priorities during the large group discussion:

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5. Establish PCSI as a standing agenda item on training conference calls

The meeting produced many additional ideas and potential action steps that will be reviewed and, where possible, addressed over the next several years. This report will be used as a basis for further discussion and prioritization within NCHHSTP in conversation with our funded training partners. The Center and Divisions are committed to moving forward on the recommendations made at the meeting. As we move forward, we will keep in mind Dr. Fenton's questions to us as a group:

- How do we become greater than the sum of our parts?
- How do we knit and weave our work to build better, more effective, services?
- How do we build on our successes?

This meeting on PCSI in CDC-Sponsored Training was a good beginning, and we anticipate building upon our successful collaboration into the future.