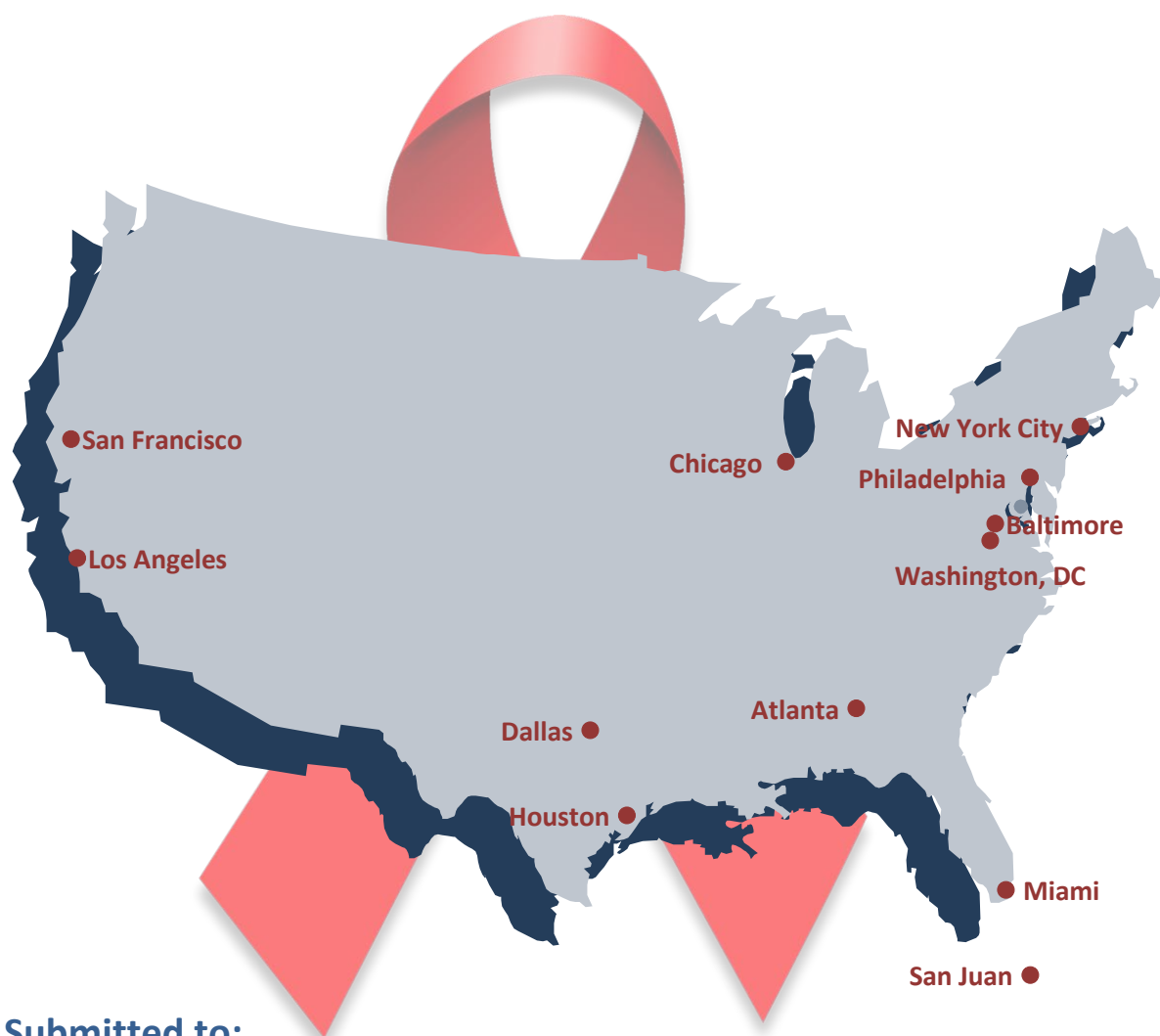

Evaluation of the 12 Cities Project: One Strategy to Improve Coordination, Collaboration, and Integration

Final Report



Submitted to:

Office of HIV/AIDS and Infectious Disease Policy
U.S. Department of Health and Human Services

November 7, 2012



Acknowledgements

- JSI would like to acknowledge our initial contacts for each of the 12 Cities: Donato Clarke (Atlanta), Heather Hauck (Baltimore), David Amarathithada (Chicago), Ann Robbins (Dallas), Marlene McNeese-Ward (Houston), Jacqueline Rurangirwa (Los Angeles), Marlene Lalota (Miami), Blayne Cutler (New York City) Coleman Terrell (Philadelphia), Dara Geckeler (San Francisco) Margaret Wolfe (San Juan-Caguas-Guaynabo), and Nestor Rocha (Washington, DC). In addition to these individuals there were many other individuals within each jurisdiction that assisted in providing information, assisting with meeting logistics and participating in meetings.
- Further, JSI wants to acknowledge the federal partner agencies who participated in interviews. These include representatives from the Centers of Disease Control, Center for Medicare and Medicaid Services, Health Resources and Services Administration, Indian Health Services, National Institutes of Health, U.S. Public Health Services, and Substance Abuse and Mental Health Services Administration
- At the Department of Health and Human Services, Office of the Assistant Secretary, Office of HIV/AIDS and Infectious Disease Policy the following staff have been tremendously helpful and supportive throughout this process: Dr. Ron Valdiserri, Vera Yakovchenko, and Dr. Andrew Forsyth.

Table of Contents

List of Acronyms

Introduction

Organization of this Report

Background on the 12 Cities Project

Evaluation of the 12 Cities Project

Purpose

Approach

Conceptual Framework

Data Collection

Notes on this Evaluation

Federal Partners Summary and Themes

Background and Purpose

Methods

Findings

Local Partners Summary and Themes

Background and Purpose

Methods

Findings

Recommendations

Appendices

Appendix A: 12 Cities Project Evaluation Fact Sheet

Appendix B: Federal Partner Discussion Guide

Appendix C: Local Partner Site Visit Schedule

Appendix D: Local Partner Visit Discussion Guide

List of Acronyms

12CP	12 Cities Project
ADAP	AIDS Drug Assistance Program
ARTAS	Antiretroviral Treatment and Access to Services
ASO	AIDS Service Organization
BPHC	Bureau of Primary Health Care
CBO	Community-based Organizations
CCI	Coordination, collaboration, and integration
CDC	Centers for Disease Control and Prevention
CFAR	Center for AIDS Research
CHC	Community health center
CMS	Center for Medicare and Medicaid Services
CPG	Community planning group
DHHS	Department of Health and Human Services
DOH	Department of Health
EBI	Evidence Based Intervention
ECHPP	Enhanced Comprehensive HIV Prevention Planning
EHARS	Enhanced HIV/AIDS Reporting System
EIIHA	Early Identification of Individuals living with HIV/AIDS
FOA	Funding Opportunity Announcement
GIS	Geographic Information System
HD	Health department
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration

IHS	Indian Health Services
JSI	John Snow, Inc.
MAI-TCE	Minority AIDS Initiative – Targeted Capacity Expansion
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary of Health
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy
PC	Planning Council
PCSI	Program Collaboration and Service Integration
PLWH	People living with HIV/AIDS
PPG	Prevention planning group
RFP	Request for proposal
SAMHSA	Substance Abuse Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
SNAP	Supplemental Nutrition Assistance Program
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
UCHAPS	Urban Coalition for HIV/AIDS Prevention Services
VA	Veteran Affairs
WIC	Women, Infants, and Children

Introduction

This report summarizes the findings of an evaluation of the 12 Cities Project, a Federal initiative to help achieve the goals of the United States' (US) National HIV/AIDS Strategy. The evaluation was undertaken by the Office of the Assistant Secretary for Health (OASH) and the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP)/U.S. Department of Health and Human Services (HHS). John Snow, Inc. (JSI) was contracted by OHAIDP to conduct the evaluation and prepare this report. The evaluation was conducted from August 2011 to July 2012.

The 12 Cities Project is an unfunded initiative that seeks to improve coordination, collaboration and integration of HIV/AIDS services among federal funders so as to improve local service delivery. OHAIDP has primary oversight of the 12 Cities Project and related activities. It advises the Assistant Secretary for Health and senior HHS officials on: the appropriate and timely implementation and development of policies, programs, and activities related to HIV/AIDS, viral hepatitis, other infectious diseases of public health significance, and blood safety and availability.

JSI is a public health and health care research and consulting company headquartered in Boston, with offices in seven other US cities (Atlanta; Burlington, VT; Concord, NH; Denver; Providence; San Francisco; and Washington, DC.) JSI has nearly three decades of HIV/AIDS and evaluation expertise. It assembled a team of staff from its Atlanta, Boston, Denver, and Washington, DC offices to accomplish this evaluation.

ORGANIZATION OF THIS REPORT

This report begins with an explanation of the 12 Cities Project, followed by a description of the evaluation conducted, including the purpose, approach, and data collection methods. The next two chapters summarize the data collection activities conducted with Federal and local partners and the key findings from these efforts. The final chapter presents the evaluators' recommendations to OHAIDP.

Background on the 12 Cities Project

In July 2010, President Obama released the National HIV/AIDS Strategy (NHAS)¹ for the US that outlined a broad vision and four goals to guide the nation's response to HIV, including:

1. Reduce new HIV infections
2. Increase access to care and improve health outcomes for people living with HIV
3. Reduce HIV-related health disparities
4. Achieve a more coordinated national response to the HIV epidemic in the US

A Federal Implementation Plan² was also released that provided details on actions the Federal Government would undertake to help achieve its part of the NHAS. In response to the implementation plan, six Federal agencies each developed operational plans for implementing the NHAS.

HHS released its operational plan in February 2011. A component of the HHS operational plan was the 12 Cities Project (12CP). As described by HHS in the plan, the 12CP, an unfunded initiative, is:

*"An effort to support comprehensive HIV/AIDS planning and cross-agency response in 12 communities hit hard by HIV/AIDS. In many ways, the 12 Cities Project is a microcosm of the NHAS itself. Namely, this demonstration project embodies many of the overarching principles of the NHAS: concentrate resources where the epidemic is most severe, coordinate Federal resources and actions across categorical program lines, and scale up effective HIV prevention and treatment strategies."*³

The 12CP was built upon a funding opportunity announcement (FOA) released by the Centers for Disease Control and Prevention (CDC) in August 2010 called *Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS* (ECHPP). The 12 Cities Project itself is an *unfunded* initiative that seeks to improve coordination, collaboration and integration of HIV/AIDS services among federally funded HIV/AIDS programs. The 12 jurisdictions representing 44% of the AIDS cases in the U.S. were eligible for and received ECHPP funding. These funds support efforts to enhance HIV prevention planning to identify and address gaps in the scope and reach of HIV prevention interventions among high-risk populations.

As described in the HHS operational plan and a 12CP fact sheet,⁴ the 12CP expanded the foundation established by the CDC FOA. It included broader goals, scope, and oversight, and aimed to engage additional Federal partners including the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health

Figure 1: The 12 Cities*

New York City, NY
Los Angeles, CA
Washington, DC
Chicago, IL
Atlanta, GA
Miami, FL
Philadelphia, PA
Houston, TX
San Francisco, CA
Baltimore, MD
Dallas, TX
San Juan, PR

*By AIDS prevalence highest to lowest

¹ The White House. 2010. *National HIV/AIDS Strategy for the United States*. Accessed online at <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.

² The White House. 2010. *National HIV/AIDS Strategy: Federal Implementation Plan*. Accessed online at <http://www.whitehouse.gov/files/documents/nhas-implementation.pdf>.

³ U.S. Department of Health and Human Services. 2011 *HHS Operational Plan: Achieving the Vision of the NHAS*. Accessed online at <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-operational-plan-hhs.pdf>.

⁴ AIDS.gov, *12 Cities Project*, accessed June 27, 2012, <http://blog.aids.gov/wp-content/uploads/NHAS-HHS-12.pdf>.

(NIH), Indian Health Services (IHS), and the Center for Medicare and Medicaid Services (CMS). At its core, the purpose of the 12CP is to address the fourth goal of the NHAS to “achieve a more coordinated national response to the HIV epidemic in the US,” which in turn, is intended to address the remaining and three primary goals of the NHAS. According to the 12CP Fact Sheet:

“By challenging HHS agencies and offices to better coordinate their planning, implementation, delivery, and evaluation of HIV/AIDS services in each of these 12 jurisdictions, HHS seeks to reduce new HIV infections, promptly diagnose those who are infected with HIV and ensure that persons with HIV/AIDS have access to continuous, quality care, so as to reduce current disparities.”⁵



Specific 12CP activities to be undertaken by HHS were described in both the HHS Operational Plan and in the 12CP Fact Sheet. The list in Table 1 was extracted from both documents.

Table 1: 12CP Activities
Convene an ongoing 12CP workgroup as well as participate in ECCHP Program and SAMHSA MAI-TCE calls
Provide a complete mapping of Federally funded HIV/AIDS resources in each jurisdiction, including Ryan White Care Act-supported services; community health centers; IHS and tribal health care facilities; CDC-supported HIV prevention activities; SAMHSA mental health, substance abuse prevention, substance abuse treatment grantees; and Centers for AIDS Research (CFAR) activities.
Share data and information across the range of HHS HIV/AIDS grantees in each jurisdiction to better inform locally coordinated planning for HIV prevention, care, and treatment.
Identify and address local barriers to coordination across HHS grantees.
Coordinate the implementation of and develop the capacity to deliver strategies and interventions addressing HIV prevention, care and treatment.
Actively promote opportunities to blend services and funding streams across Federal programs.

⁵ AIDS.gov, 12 Cities Project, <http://blog.aids.gov/wp-content/uploads/NHAS-HHS-12.pdf>.

While the activities in Table 1 were those to be taken at the HHS level, the 12CP also assumed the active participation of local partners, including state and local health departments, HIV organizations, community members, and people living with HIV/AIDS (PLWH). In this way, 12CP was expected to have both Federal and local effects -- Federal activities would have effects on local efforts, and local partners would undertake their own activities in support of the 12CP and the NHAS.

Evaluation of the 12 Cities Project

In August 2011, OHAIDP contracted with JSI to conduct a one-year evaluation of the 12CP. In this section, we describe the purpose of the evaluation, our approach and conceptual framework, data collection methods, and validity.

PURPOSE

The purpose of the evaluation was to assess the processes and activities supported by the 12CP and specific progress toward the fourth goal of the NHAS of achieving a more coordinated national response to the HIV epidemic in the US. While the 12CP is a Federal initiative with Federal activities, the focus of the evaluation was not on evaluating efforts at the Federal level, but rather on assessing (1) whether Federal efforts had produced any impact on coordination, collaboration, and integration (CCI) at the local level and (2) to document whether local jurisdictions had undertaken any CCI efforts of their own. Information gathered from the evaluation would help OHAIDP assess the effectiveness of the initiative, make recommendations to address challenges and/or enhance activities, and identify and share best practices.

APPROACH

Based on the purpose of the evaluation, the type of information that was desired by OHAIDP, and the relatively short time that 12CP had been underway (about one year), JSI and OHAIDP agreed on a qualitative approach for the evaluation.

A qualitative approach is particularly well suited for a study or evaluation in which the purpose is to explore meaning, context, processes, and/or explanations.⁶ Table 2 describes these strengths of qualitative approaches, their general definitions, and their applicability to the 12CP evaluation.

Table 2: Qualitative Approach and Applicability to 12CP Evaluation

Qualitative Focus	General Definition	Application to 12CP Evaluation
Meaning	Participant perspectives and how they understand phenomena being studied	Local partners understanding of the purpose and role of 12CP
Context	Situation of participants and how events, actions and meanings are shaped by local circumstances	Local factors that have affected implementation of 12CP in each jurisdiction
Processes	How events occurred or actions were undertaken, and how they led to particular outcomes	Activities undertaken by local partners related to 12CP and purpose or goals of those actions
Explanations	How X plays a role in causing Y, and the process that connects X and Y	Potential impacts of 12CP and Federal activities on jurisdictions

⁶ Maxwell, Joseph. 2004. *Qualitative Research Design: An Interactive Approach*. Thousand Oaks, CA: Sage Publications.

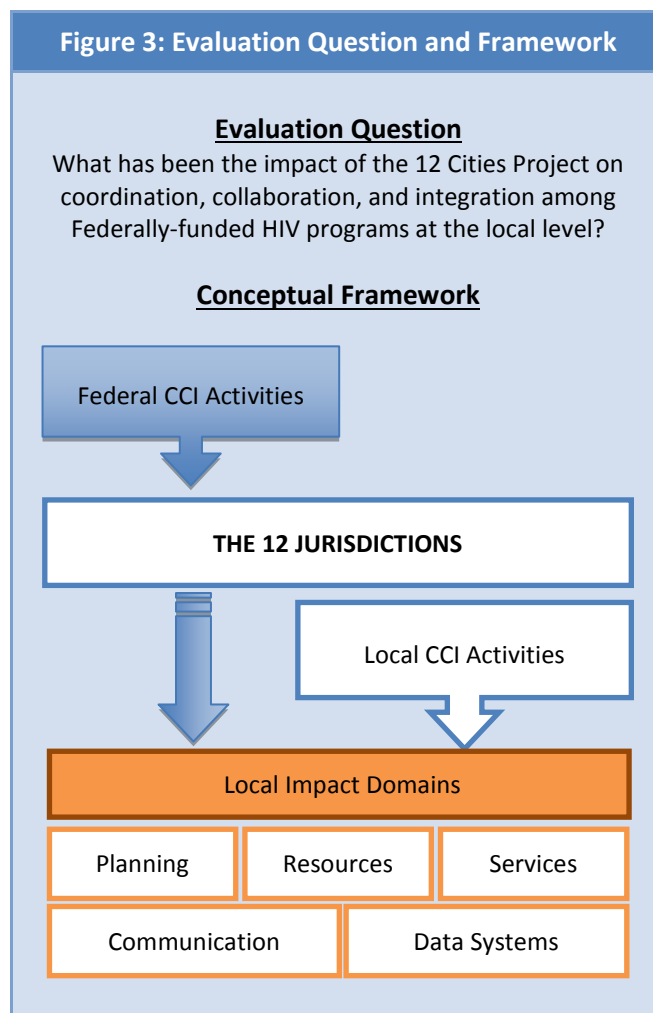
CONCEPTUAL FRAMEWORK

Based on the description of the 12CP and the purpose of the evaluation, JSI and OHAIDP developed a question and a conceptual framework to guide the evaluation activities (see Figure 3). The evaluation question was: ***What has been the impact of the 12CP on coordination, collaboration, and integration (CCI) among Federally-funded HIV programs at the local level?***

The framework was based on the assumption that activities had been undertaken at the Federal level as part of the 12CP to improve CCI and that those activities may have had some effect on the local jurisdictions. The evaluation would explore whether those activities had indeed produced any impacts on CCI at the local level, and concurrently, whether local partners had taken up the call of the 12CP and implemented local CCI activities too.

As part of the framework, JSI and OHAIDP decided to focus the evaluation on five “domains” in which CCI may have occurred: (1) planning, (2) resources, (3) programs/services, (4) communication, and (5) data systems. These domains guided the data collection activities detailed in the section below.

- **Planning:** Included comprehensive planning efforts for a range of HIV care, treatment, prevention, research, and related services. With the foundation provided by ECHPP and its required enhanced HIV prevention planning in the 12 jurisdictions, it was anticipated that there could be additional CCI efforts in this domain.
- **Resources:** Included a range of Federal, state, and local funding for HIV and related health issues such as sexually transmitted infections (STIs), TB, and hepatitis, among others. CCI in this domain could include strategic efforts to use resources more efficiently and effectively across funding sources (e.g., blending or “braiding”).
- **Services:** Included any HIV and related prevention, care and treatment services. While similar to funding, this domain refers to how programs and services are implemented and/or strategies for responding to the HIV epidemic.
- **Communication:** Included information sharing and other mechanisms for ensuring communication among local stakeholders. This may include communication within or across programs or organizations, or institutions.
- **Data Systems:** Included any of the range of HIV and related health data collection and reporting systems to meet local, state, or Federal reporting requirements, as well as monitoring, evaluation, research, or planning needs.



Coordination, Collaboration, and Integration. Given the focus of the evaluation on CCI, JSI established working definitions of each concept to help guide data collection and interpretation. JSI drew most heavily upon the program collaboration and service integration (PCSI) efforts of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

CDC has long recognized the potential for including the identification and treatment of sexually transmitted infections (STIs) as part of HIV prevention efforts. As evidence mounted of the links between HIV risk and TB, STI, and viral hepatitis infection, CDC began to focus on collaboration and integration of related prevention services. In 2007, CDC published a “green paper”⁷ on PCSI, followed in 2009 by a white paper on the topic.⁸ Drawing upon this white paper, as well as the team’s expertise, JSI identified working definitions of coordination, collaboration, and integration (see Table 3).

JSI also drew upon research⁹ to further elaborate the concept of collaboration. According to this research, collaboration includes five variable “dimensions” including:

1. **Governance:** How participants jointly make decisions.
2. **Administration:** Structures that exist or are developed to move from governance to action.
3. **Autonomy:** The tension that exists between the organizational self-interest of participants and the collective interests of collaboration.
4. **Mutuality:** Shared beneficial “interdependencies” based on either common or differing interests.
5. **Norms:** Notions of reciprocity and trust that guide the expectations and actions of participants.

Table 3: Definitions of CCI Concepts
<ul style="list-style-type: none"> • Coordination: Planning between stakeholders to ensure that their work, while being performed independently, is complimentary and non-duplicative in nature. • Collaboration: Two or more parties working together on a defined project/program in order to achieve a more efficient and/or effective outcome that would be difficult to achieve otherwise. • Integration: Provision of seamless services from multiple programs within one setting that can result in the reduction of duplication and barriers to access of needed care.

The definitions of CCI concepts were used internally by the JSI team to provide a common language and framework for understanding and interpreting 12CP activities explored as part of this evaluation. However, to focus data collection activities, JSI developed a working definition of CCI (see Table 4) to share with participants in the evaluation.

Table 4: Definition of CCI
Efforts to provide a more comprehensive and seamless approach to addressing the HIV epidemic that may involve your agency or organization and other person(s), agency (-ies), and or organization(s).

This was intended to provide enough information to focus stakeholder input, but avoid unnecessary attention to the meanings of the specific concepts and their relationship to their activities. It was hoped that this would enable participants

⁷ CDC. 2007. *Program Collaboration and Service Integration: Enhancing the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States. An NCHHSTP Green Paper.* Atlanta (GA): HHS, CDC

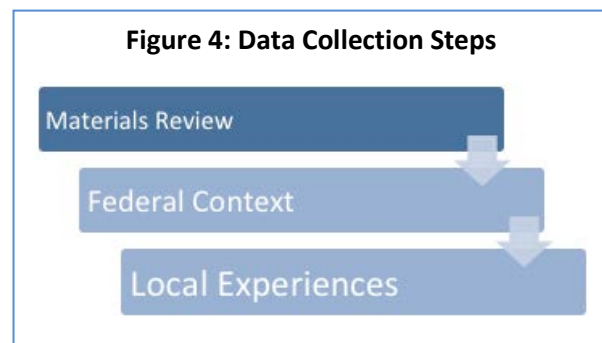
⁸ CDC. 2009. *Program Collaboration and Service Integration: Enhancing the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States.* Atlanta (GA): HHS, CDC.

⁹ Thomson, Ann M, James L Perry, and Theodore K Miller. 2007. *Conceptualizing and Measuring Collaboration. Journal of Public Administration and Theory.* Advance access, published December 1.

to describe 12CP activities in their own words, and allow the JSI team to interpret or categorize these activities using the definitions it had developed.

DATA COLLECTION

The first step in the data collection process was a comprehensive review of background materials about the 12CP and related initiatives. Most significantly, this included an in-depth review and internal discussion of the ECHPP plans developed by each jurisdiction, as well as copies of presentations made by each jurisdiction to OHAIDP in the summer of 2011 describing 12CP activities.



This background step provided the team with a better understanding of the local context and the types of activities that each jurisdiction was undertaking in response to ECHPP and 12CP, and it helped inform the team's subsequent data collection activities.

Because the 12CP was a Federal initiative, information about Federal activities provided important context for local data collection efforts. JSI held eight discussions with Federal agencies (summarized beginning on page 8 of this report) to gather information on Federal activities and perspectives on the 12CP. This information informed the data collection activities at the local level, which was the primary focus of the evaluation project. Discussions were also held later in the project with two national organizations (UCHAPS and the National Alliance of State and Territorial AIDS Directors) to provide additional insight into the 12CP and its implementation at both the national and local levels.

To gather information from the local partners, JSI held discussions with key stakeholders in each of the 12 jurisdictions. For 11 of 12 jurisdictions, discussions were held as part of a one- to two-day site visit conducted by two members of the JSI team; for the twelfth jurisdiction, discussions were held by phone. In each jurisdiction, JSI met with and held discussions with three key groups of people: (1) health department staff, (2) community planners, including service providers and consumers (HIV-positive community leaders as well as clients), and (3) other stakeholders or groups that had been involved in local 12CP efforts.

Descriptions of the data collection tools, protocols, and processes for the discussions with Federal and local partners are provided in the corresponding sections that follow. Copies of relevant data collection tools are provided in the appendices.

NOTES ABOUT THE EVALUATION

Based on the information described above, this project was both a formative and process evaluation. Formative evaluations are usually conducted early in an initiative's implementation to assess whether it is producing the intended effect and/or if any modifications are necessary to help ensure it achieves its objectives. At the time this evaluation was begun, the 12CP was relatively new – the HHS operational plan had been released about six months earlier. In addition, the 12CP was and remains a "demonstration project." For both reasons, the evaluation had a formative focus, enabling OHAIDP not only to assess the early progress of the 12CP, but also gather information that may inform future efforts (e.g., enhancements to the project, or expansion to jurisdictions beyond the initial 12 cities).

Process evaluations are designed to identify and monitor activities conducted as part of the implementation of a project or initiative. Process evaluations focus on what activities, services, or actions had been undertaken to achieve a project's goals or objectives. Given OHAIDP's interest in understanding what progress had been made as part of the 12CP, this evaluation was also process oriented.

Outcome evaluations assess whether goals and objectives have been met and identify the overall impact of a project or initiative. The evaluation of the 12CP was not outcome-focused, although some evidence of successful implementation of its goals is identified. Future evaluation efforts could focus on outcomes of 12CP and/or the range of activities aimed at achieving the NHAS.

Caveats. Before presenting the findings, it is important to note and describe several factors that may have affected the implementation of the 12 Cities Project, the data we collected, and/or our analysis. These factors should be considered when interpreting and/or using the results of this evaluation.

1. ***The 12CP as a concept.*** As described in the introduction of this report, 12CP was launched as a demonstration project with the goal of better coordinating HIV/AIDS activities across Federal agencies and funded programs. The 12CP was presented in a fact sheet that outlined goals and related Federal activities. However, no funding announcement or Federal guidance was provided that articulated expectations for local implementation. Operationalization of the 12CP at the local level occurred in this context, contributing to considerable variations in understanding, interpretation, and implementation. For example there was no standard definition of collaboration, coordination or integration provided to the 12 jurisdictions. Compared to ECHHP, some participants said that the 12CP lacked visibility and clear goals. As one participant explained, the "12 Cities is a philosophy without an implementation plan."

2. ***Timing.*** This evaluation began approximately one year after the release of the NHAS, and about six months after release of the HHS Implementation Plan. Because of the short period of time, this evaluation is necessarily formative and process-focused in nature. Assessment of outcomes was not possible in this timeframe.

3. ***Context.*** Implementation of 12CP occurred within the context of a severe economic recession and progress toward healthcare reform in the US. In addition, it was implemented nearly 30 years into the HIV epidemic, upon a foundation built from years of incremental progress and evolution in HIV prevention, care, and treatment, including several recent Federal HIV initiatives that have encouraged or promoted CCI in various ways (e.g., PCSI, EIIHA, and ECHPP). As a consequence of these economic, policy, and historic contextual factors, it is not possible to attribute CCI activities exclusively to 12CP (or to demonstrate a causal link between 12CP and CCI at the local level). The themes and activities identified below are those for which 12CP was identified as a likely contributing factor.

4. ***Methodological limitations.*** Information gathered during the discussion groups was self-reported by participants who were identified and selected by the local contact in each jurisdiction, while Federal agency contacts were identified by OHAIDP staff. Independent verification of themes was not conducted. This has the potential to introduce bias into the analysis. However, JSI took several steps to minimize this methodological limitation. First, JSI provided clear guidance to the local partners about the range of individuals and expertise to involve in the discussions and worked closely with local contacts to ensure diversity of participants and perspectives. Second, JSI informed the local contacts, as well as all discussion group participants, that the purpose of the site visits and discussions was not to evaluate

local performance, but rather to learn about local activities. Third, discussions with Federal partners and other national organizations provided important context for comparison and interpretation.

Federal Partners Summary and Themes

BACKGROUND AND PURPOSE

As described previously, 12CP is an unfunded Federal initiative addressing the fourth goal of the NHAS to improve the CCI of Federally-funded HIV programs. While the focus of this evaluation was to assess the impact of the 12CP at the local level, an important component of the overall evaluation plan was to gather information about the various activities undertaken by Federal partners related to the 12CP.

This data collection step served at least two purposes. First, it ensured that the overall evaluation included information and insights from the Federal partners who have had a role in the 12CP implementation. Second, it provided important contextual information that informed subsequent data collection efforts. When combined with the background data review previously described, information gathered from the Federal partners provided a solid foundation for the exploration and identification of the local impacts of these activities during the site visits in each jurisdiction.

METHODS

Approach. In consultation with OHAIDP, JSI proposed to conduct a series of group and one-on-one discussions by phone with Federal partners in homogeneous groups (meaning each group would include representatives from the same Federal agency). OHAIDP proposed that JSI hold discussions with representatives from CDC, SAMHSA, NIH, IHS, and HRSA. Details on the specific programs represented by participants in these discussions are provided in Table 5.

Tool development. To guide the discussions and gather relevant information, JSI developed a standard tool (see *Appendix B*) that included an introductory script explaining the evaluation and the purpose of the discussion, and a series of questions and probes exploring the following topics:

1. Understanding of the goals and purpose of the 12CP
2. Changes in the way the agency works or implements programs as a result of 12CP
3. Key successes of the 12CP (to date and anticipated)
4. Challenges of implementing the 12CP
5. Additional activities that could enhance coordination, collaboration, and integration at the Federal, state, and local levels

Recruitment. Federal partners by agency/program were identified and their contact information provided to JSI by OHAIDP staff. JSI staff contacted each group of participants by email and requested their participation in a 60-minute phone call. JSI provided a fact sheet about the project in the initial contact email, and after a date/time for the call had been confirmed, provided an edited version of the discussion guide so that participants could prepare for the discussion.

Implementation. Between mid-December 2011 and mid-February 2012, JSI conducted eight calls with 27 individuals across five Federal agencies (see Table 5).

Table 5: Federal Partner Discussions

Federal Agency	Representation	Calls	Federal Participants
CDC	<ul style="list-style-type: none"> Leadership Staff 	1	3
CDC	<ul style="list-style-type: none"> Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project Officers 	1	4
HRSA	<ul style="list-style-type: none"> HIV/AIDS Bureau (HAB) Bureau of Primary Health Care (BPHC) Bureau of Health Professionals (BHPr) Office of Regional Operations (ORO) 	1	9
IHS	<ul style="list-style-type: none"> Urban Indian Health Program 	1	2
NIH	<ul style="list-style-type: none"> Centers for AIDS Research (CFAR) Program Officers 	1	2
SAMHSA	<ul style="list-style-type: none"> Minority AIDS Initiative – Targeted Capacity Expansion (MAI-TCE) Project Officers 	3	7
	Total	8	27

Each call lasted approximately 60 minutes and included between one and nine Federal participants. Two JSI staff members participated in each call, with one leading the discussion and the other taking notes and asking clarifying probes. One Federal partner group (HRSA) submitted written responses to the discussion guide in advance of the call, and the discussion focused on clarifying those responses and exploring in more depth some of the activities and challenges related to 12CP.

Upon consent from participants, calls were recorded using AT&T conference call recording services or a handheld, digital recording device.¹⁰ At the completion of each call, the digital recording was downloaded and saved on JSI’s secure servers. JSI staff then prepared a written summary of each call using their notes and the recordings. Neither the notes nor the recordings were shared with OHAIDP.

Analysis. Given the manageable amount of information collected, standard manual qualitative data techniques were used to analyze the discussion groups. The written note summaries were reviewed and coded to identify themes across the groups. Unique issues and concepts were noted. Key findings are summarized in the next section.

FINDINGS

Understanding of 12 Cities Project. The first question of participants focused on assessing their knowledge and awareness of the 12CP and its goals and objectives. Responses indicated that nearly all participants were aware of 12CP. Most described the project as focused on collaboration and integration of resources, and/or using resources most efficiently and effectively to address the HIV epidemic in those areas with the highest burden.

The understanding of 12CP was stronger and more nuanced among traditionally HIV-focused Federal partner programs. For example, CDC and HRSA participants were able to describe and reference specific objectives of 12CP, including those listed on the 12CP Fact Sheet. Among other partners, understanding

¹⁰ Consent to record was not granted for one call held with a single SAMHSA representative who was unable to participate in prior calls with other SAMHSA representatives.

of 12CP was more variable, ranging from little to no understanding of the project, to more general reference to the goals of the NHAS, to more accurate descriptions of the stated 12CP goals and objectives. Among those with little understanding of 12CP, there was only a vague association between 12CP and increased coordination, but no specific objectives could be named. Some partners had a broad understanding of the 12CP focus on collaboration and efficient use of resources, but a narrower focus on agency-specific contributions of ensuring access to or integration of specific services (e.g., behavioral health) or addressing the needs of specific populations (e.g., homeless, American Indians, etc.).

Participants from CDC were able to differentiate ECHPP, 12CP, and NHAS while those from HRSA/HAB referred explicitly to the 12CP fact sheet/overview and acknowledged ECHPP as a CDC grant-funded initiative and 12CP as an HHS-wide effort. But HRSA/HAB participants also expressed confusion about what distinguishes 12CP from ECHPP, NHAS, and even Ryan White legislative and programmatic requirements; they also indicated that their grantees have experienced similar confusion.

Impact on How Agencies Work. Among the Federal partners included as part of this data collection activity, it was clear that the NHAS and the 12CP have produced changes in how agencies function in response to the HIV epidemic. One impact of the 12CP most often described was how it helped to provide a rationale for more coordination among Federal partners. As one participant described it, the NHAS and 12CP have provided almost “intangible” benefits – a structure/framework or organizing principle that has (1) guided, redirected, or refocused activities, and (2) been a facilitator (“it helped open doors”) that has encouraged people to work together, leverage partnerships, and share information within their own organization and across organizations.

Participants described an extensive list of specific activities they have undertaken. These are described in more detail in the next section. In general, we note the following themes related to changes in how agencies work:

- **Greater and more frequent communication within and across agencies.** Nearly all participants described enhanced communication across agencies, either through collaboration on specific initiatives, or participation in cross-agency workgroups (e.g., HHS Indicators, ECHPP Implementation, CDC Data Sharing, and Minority AIDS Initiative-Targeted Capacity Expansion, among others), steering committees, and/or other meetings related to NHAS, ECHPP, or 12CP. In addition, several partners described enhanced communication within their agencies, with staff working together across divisions and/or participating on internal teams to address NHAS, ECHPP, or 12CP. These communication efforts were welcome opportunities to learn more about what their colleagues do, obtain information more readily or build collaborative efforts.
- **Intensification of focus on and resources available in the 12 jurisdictions.** All participants described a range of activities to increase the focus on and availability of resources in the 12 jurisdictions. These activities are described in more detail below, and reflect a clear effort to mobilize an extensive array of resources to address the HIV epidemic in the 12 jurisdictions.
- **Increased focus on reducing reporting burden but ensuring ability to measure systems-level changes and outcomes.** The ability to measure the impact of HIV programs was a clear priority among participants. While successes were yet not demonstrable, participants described numerous ongoing Federal efforts aimed at streamlining data collection, sharing data resources, and developing common indicators. In addition, some participants described a shift from evaluating single interventions or programs, toward evaluating the combined effect of multiple interventions or programs on a system.

Specific 12 Cities Project-Related Activities. Federal partners described an extensive range of activities and initiatives undertaken in response to NHAS, ECHPP, and 12CP. It is important to note that our ability to attribute these activities exclusively to 12CP is limited. Other than the CDC ECHPP Project Officers, for whom ECHPP was their primary focus, participants generally elided NHAS, ECHPP, and 12CP. This makes the challenge of specific attribution of particular activities to 12CP difficult for most informants to assert without hesitation. As one participant said “As long as the activities address the NHAS goals, isn’t that enough?” Below, we describe the activities noted by participants, by agency, in alphabetical order.

CDC Partners. In general, the discussions with CDC focused on ECHPP and the intensification of efforts within the 12 jurisdictions as part of that initiative. Because discussions did not include staff across all of CDC’s branches involved in HIV work, it is likely that some efforts and initiatives related to 12CP or the NHAS were not mentioned. For example, we did not speak to staff within the CDC’s Capacity Building Branch or the Program Evaluation Branch. Yet we are aware of other activities that may be directly or indirectly related to 12CP (e.g., refocusing on specific EBIs, developing training for new prevention strategies for priority populations, or developing a methodology for calculating the frequency of HIV testing within the jurisdictions). Nonetheless, participants described the following activities (note, activities are listed in order from those most clearly supported by 12CP to those least clearly guided by the 12CP):

- Enhanced internal and cross-agency focus and communication about data collection, data sharing, and streamlining was clearly supported by 12CP.
- Conducted conference calls with the 12 jurisdictions to open communication between health department staff and Federal government officials.
- Structured evaluation efforts to require more systems-level outcomes rather than focusing solely on individual program activities.
- Provided each jurisdiction with a team of CDC staff to assist with implementing ECHPP. This has enhanced communication and allowed CDC to mobilize its staff to provide the jurisdictions with additional resources, expertise, and technical assistance.
- Issued more focused or “prescriptive” FOAs, including ECHPP and the flagship FOA for health departments, to guide or direct funded activities in support of NHAS.

HRSA Partners. In the written response submitted in advance of the discussion call, HRSA participants provided a summary table of the 12CP, extracted from the 12CP fact sheet/overview, which listed the key principles, basic approaches, and specific actions of the 12CP. HRSA then indicated four of the “specific actions” in which it had been involved. This included: (1) sharing programmatic data, (2) streamlining reporting requirements, (3) identifying and addressing local barriers to collaboration, and (4) developing common measures and evaluation strategies. During the call, HRSA described a range of activities across its bureaus (described below) and as part of that discussion, decided it had also contributed to a fifth specific action -- coordinating implementation of and developing capacity to deliver HIV prevention, care, and treatment strategies. The specific activities described by HRSA participants on the call included:

- Participated in ECHPP working group, 12CP steering committee, and other groups and meetings.
- Provided training and developed talking points for project officers to build awareness and understanding of NHAS and 12CP.
- Conducted and shared an inventory of existing Federal activities (e.g., Ryan White HIV/AIDS Program and BPHC grantees) in the 12 jurisdictions.

- Shared information with other Federal partners, such as Ryan White HIV/AIDS Program unmet need calculations and existing data variables to support development of common metrics).
- Provided guidance to grantees about 12CP, including distributing a letter encouraging participation in ECHPP and 12CP, developing grant application and Statewide Coordinated Statement of Need (SCSN) guidance that requires participation in 12CP activities, and holding a webinar for Ryan White HIV/AIDS Program Part A and B grantees with Assistant Secretary of Health and CDC staff.
- HRSA/HAB has implemented three MAI-funded initiatives with a 12CP focus:
 - National Center for HIV Care in Minority Communities: Funded by HRSA’s AIDS Education and Training Centers (AETC) and Minority AIDS Initiative (MAI), this project targeted 30 community health centers that do not receive Ryan White HIV/AIDS Program support to help build HIV clinical capacity. Of the 24 programs accepted, HRSA required that at least one-half be in the 12 jurisdictions.
 - Ask, Screen, and Intervene: This initiative supports the implementation of an adapted CDC “Prevention with Positives” intervention. It is being implemented in eight Ryan White HIV/AIDS Program Part C-funded clinics in four of the 12 jurisdictions (Baltimore, Chicago, Miami, LA). In addition to adapting strategies from CDC, the training for the interventions is being conducted by AETCs and CDC’s Prevention Training Centers (PTCs), representing another collaborative aspect of the project.
 - Retention in Care Project: This is a HRSA and CDC collaboration to implement prevention case management in three of the 12 jurisdictions (New York, Miami, and San Juan).
- BPHC has implemented several activities with a 12CP focus:
 - Training: Conducted training for BPHC project officers to increase their awareness of the initiative and enhance HIV knowledge.
 - Performance Improvement Activities (PIAs): PIAs are action items assigned to a grantee by their project officer for attention during their grant period. In response to 12CP, BPHC developed a “menu” of HIV-related PIAs. POs monitoring grantees in the 12 jurisdictions were required to select at least one HIV-related PIA for their grantees. If the grantee was also receiving Ryan White Program funding, the BPHC project officers were also asked to contact the HRSA/HAB project officer for that grantee as part of the PIA selection process.
 - Primary Care Associations. BPHC has worked with Primary Care Associations to expand trainings to improve HIV and cultural competency of providers.
- ORO noted the following
 - Helped facilitate Region II meeting in New York that included NHAS focus, and described a similar regional meeting in Chicago that was then replicated in Minneapolis (a non-12CP jurisdiction).
 - Has regional field staff whose primary function is information sharing; they can be a resource for 12CP to facilitate communication between Federal government and state/local stakeholders.

IHS Partners. Activities described by IHS participants suggest that it is a newer partner in 12CP. In general, activities described reflect an effort to be “at the table” and ensure that the needs of American Indians and Alaska Natives (AI/AN) are part of the broader NHAS and 12CP efforts. Specifically, IHS described the following activities:

- Provided mini-grants to two local sites that overlap with the 12 jurisdictions to support efforts to participate in local planning and implementation.

- Participated in the 12CP Steering Committee, which enabled input in discussions about the strategic use of resources and the specific concerns of AI/AN population.
- Used planning around 12CP as opportunity to discuss streamlining data reporting, and improving documentation of clients served.
- Provided explicit communication with grantees that they are receiving resources because of what the data show, underlining the need for the collection and reporting of data on PLWH

NIH Partners. Participants from NIH, affiliated specifically with the Centers for AIDS Research (CFAR), indicated that their activities have focused on linking CFARs to key stakeholders in the 12 jurisdictions. Specifically, nine of NIH’s 20 Centers for AIDS Research are within the 12 jurisdictions. These CFARs have been directed to collaborate with the health departments in these nine cities. To support this directive, NIH provided an administrative supplement to help CFARs collaborate with the health departments and address how they could help implement ECHPP. Typically, CFAR grants provide infrastructure support for institutions conducting research on HIV/AIDS. These supplemental awards support activities negotiated between CFAR sites and local health departments to further goals related to 12CP, ECHPP, or NHAS. In some jurisdictions with historically weak relationships between the CFAR and the health department, this helped strengthen these relationships. As described in the following section on findings at the local level, a number of national and local meetings have been held to build these relationships.

SAMHSA Partners. In general, participants from SAMHSA focused on two sets of activities. First, 12CP has encouraged “cross center” collaboration (i.e. substance abuse prevention, treatment and mental health services) within SAMHSA and a consolidation and integration of efforts. Second, the recent MAI Targeted Capacity Expansion (MAI-TCE) funding opportunity was cited as a specific 12CP initiative that is intended to support the integration of behavioral health into HIV primary care and the integration of HIV prevention (including testing) into behavioral health services. The MAI-TCE provides funding for 11 of the 12 jurisdictions (excluding Houston). In addition to promoting the integration of services, participants also reported that the MAI-TCE initiative has:

- Represented a new collaboration between SAMHSA and CDC, both in the development of the funding opportunity and in its implementation. The collaboration has enabled staff (particularly project officers) at SAMHSA and CDC to learn more about their respective programs.
- Created greater links between SAMHSA and the local health departments in the funded jurisdictions. Similar to CDC’s ECHPP effort, SAMHSA is pulling upon expertise across the agency to support the grantees in the jurisdictions and is holding bi-weekly calls to help identify challenges and mobilize resources to respond. Several HIV/AIDS programs in the 12 jurisdictions are working closely with local substance abuse programs for the first time as a result of this.

Participants noted that the MAI-TCE is a new initiative (four months old at the time of the interviews). As such, outcomes and impacts of this effort are not yet visible.

SAMHSA participants also reported that it has worked with CDC and HRSA on several other initiatives (training centers and methadone and HIV testing with CDC, and SPNS project with HRSA).

Challenges. All participating Federal partners were asked to describe the biggest challenges for implementing the 12CP at the Federal level. Challenges identified included:

- Understanding 12CP and how it differs from ECHPP has taken some time, and still creates confusion among some Federal partners and their grantees.

- 12CP was not “tied to funding,” and as such, did not have prescribed activities, expected/anticipated outcomes, and/or evaluation measures that could be used with grantees to help produce results.
- The focus on data-driven decision-making is good, but it is a challenge if the data are not available for some populations (e.g., AI/AN).
- Overall, the HIV/AIDS system in the US is still “under-resourced” and budgets are limited. This poses a particular challenge for agencies in which the primary mission is not HIV prevention or care and treatment.
- For some agencies without an HIV-specific mission, NHAS or 12CP is not a primary focus of their work and staff members have significant other duties related specifically to their mission.
- Data issues remain a significant challenge. This includes streamlining data collection and reporting, facilitating data sharing, addressing de-duplication, and responding to different reporting requirements (some driven by legislative language).
- It was suggested that local grantees have been better able than Federal partners to integrate services funded by different Federal agencies; however, being able to disaggregate service level data for each funder’s reporting requirements is a real challenge.
- It may be too early into the NHAS and 12CP to see its impacts. As one participant said, “This is a huge shift and it will take time,” not just for the Federal partners, but also the local jurisdictions. In addition, Federal partner participants described a range of recent and new initiatives including MAI-TCE, regional meetings and streamlining of reporting for which progress is underway but it is too soon for outcomes to be clear.
- Increased resources and focus on the 12 jurisdictions has also brought increased scrutiny (such as this evaluation). Time spent responding to Federal information requests and participating in related meetings and phone calls diverts local resources to address 12CP or NHAS.
- It is possible that there are opportunities for increased CCI that Federal partners are missing, simply because they do not know they exist.
- Some Federal partners have unique roles (e.g., NIH or HRSA’s ORO), so it is more difficult to determine how they “fit” and can make a difference to the 12CP.
- Statutory or legislative language prevents flexibility and poses barriers for budget/funding integration, as well as data streamlining. This was noted specifically by HRSA and SAMHSA. The law “trumps” all else, so meeting legislative mandates will continue to take priority.

Future Success. Federal partner participants were also asked their thoughts on what would make 12CP a success, looking two to four years into the future. Overall, participants described “success” as sustainable progress toward achieving the goals of NHAS (e.g., reducing new infections, increasing access to care, and reducing disparities). Other notable measures of success included reduced reporting burden for grantees, and greater Integration of programs Federally and locally, including the integration of behavioral health services into primary care for PLWH.

Across the US there have been several regional meetings convened by the Regional Health Administrators and Regional Resource Coordinators to coordinate activities to implement the NHAS including meetings (at the time of the study) in Regions II, IV and VIII¹¹ and meetings have now occurred in each region.

¹¹ <http://www.aids.gov/federal-resources/national-hiv-aids-strategy/implementation-progress/federal-implementation/>

A number of respondents mentioned the need for approved measures that can be used to assess progress, including common indicators across programs. It was noted that achieving a set of common indicators is challenging and that there are some important indicators, such as HIV incidence, that are important to track but are not necessary for more than one agency to collect and report.

There was also an interest in having both quantitative and qualitative measures. Qualitative measures were framed mostly in terms of cooperation among agencies. One respondent phrased it as “how well are we ‘shaking hands’ in 3-5 years.” Another framed it as whether there would be better cooperation among Federal partners beyond HIV/AIDS. This included global measures in accordance with the NHAS such as reduction of new infections, increased linkage to and retention in care, improved viral suppression and reduction of disparities in those measures among subpopulations.

SUMMARY

The 12CP and NHAS have encouraged a robust response from Federal partners. The range of activities and efforts has been substantial and reflects a commitment to doing things differently and mobilizing resources effectively and efficiently in response to the NHAS.

There was some indication that local partners may not have been aware of the range of Federal efforts undertaken as part of 12CP. This includes collaborative activities within and across Federal agencies such as participation in Federal level workgroups or other efforts to increase communication among Federal partners), and specific initiatives that either did not involve local health departments (e.g., HRSA/HAB’s *Ask, Screen, and Intervene* initiative) or may not be “visible” to local partners (e.g., HRSA/BPHC’s performance improvement activities implemented with its grantees).

This data collection activity with the Federal partners provided important information and context for the next phase of this evaluation – identifying and assessing the impact of these Federal activities in the 12 local jurisdictions. The data collection activities and findings from the local partners are discussed in the next chapter.

Local Partner Summary and Themes

BACKGROUND AND PURPOSE

As previously noted, the purpose of this evaluation was to explore the impact of the 12CP at the local level, including how Federal activities have played out locally and whether any local initiatives were undertaken to help meet the objectives of the 12CP. As such, discussions with local partners were the key source of evaluation data and were the focus the evaluation (and this report).

It is important to note that the intent of data collection activities with local partners was not to evaluate their performance against a set of objective criteria, benchmarks, or other indicators. Instead, it was an attempt to understand progress toward CCI at the local level across jurisdictions, and identify successes and challenges they have experienced.

METHODS

Approach. The approach for gathering data from local partners was a series of discussions held with groups of stakeholders in each of the 12 jurisdictions. The stakeholder groups were defined generally as: (1) health department staff, (2) community planners (including service providers and people living with HIV), and (3) other groups or stakeholders who had been involved in 12CP activities.

For 11 of the 12 jurisdictions, JSI conducted discussions through in-person site visits held over one to one and one-half days. For the twelfth jurisdiction, discussions were held through conference calls conducted over a period of several weeks. Each site visit included two members of the JSI evaluation team, one of whom was designated as the “coordinator” for the site.

Tool development. To guide the discussions and gather relevant information from each group, JSI developed a standardized tool (see *Appendix D*) that included an introductory script explaining the evaluation and its purpose, the role of the discussion groups, and a series of questions and probes to be used by the facilitator. The tool also explained that the discussion were not intended to evaluate local performance, but rather to assess the 12CP overall.

The same tool was used for all three target participant groups. JSI also produced an edited version of the tool, with probes and instructions removed, for distribution to participants in advance of the visit to enable preparation. The discussion tool focused on exploring the following topics:

1. Understanding of the goals and purpose of the 12CP
2. Progress toward increased CCI of Federally funded HIV/AIDS prevention, treatment, and care services locally
3. Groups, organizations, or individuals that were involved in efforts to increase CCI
4. Factors that helped or hindered efforts to improve or increase CCI
5. Technical assistance that was received or needed
6. Monitoring and measurement of CCI activities

Recruitment. For each jurisdiction, the ECHPP coordinator was the initial point of contact for local data collection efforts. OHAIDP distributed a letter by email to these individuals, explaining the project and introducing JSI as the evaluator. This message included a “fact sheet” (see *Appendix A*) developed by JSI that explained the purpose of the evaluation and the expectations for local participation.

JSI assigned two team members to each jurisdiction, with one serving as the coordinator for the site. After the initial message from OHAIDP, the JSI coordinator emailed a letter to each local point person to introduce JSI and the evaluation, and to provide notice that he/she would be calling the contact to discuss the jurisdiction's participation.

The primary JSI staff person for each jurisdiction then followed up on this note with a series of calls and email messages. Initially, these conversations focused on describing the purpose of the evaluation, the broad outlines of the site visits, and the targeted groups for discussions. In later conversations, the JSI coordinator worked with the local contact person(s) to develop a site visit date and agenda, and to discuss and identify appropriate groups of individuals for the discussions. Selection of participations and groups was determined by the point person in the jurisdiction.

Implementation. JSI conducted site visits with 11 jurisdictions and telephone interviews with one jurisdiction (see Table 6) between February and April 2012. Each visited lasted one to two days and included from two to seven meetings. Additional information about the site visits is provided in *Appendix C*.

Table 6: Site Visit Information

City	Meetings Held	Total Participants	Date of Visit (2012)
Atlanta	5	35	February 22 & 23
Baltimore	3	24	April 6
Chicago	3	24	February 28 & 29
Dallas	5	20	February 22 - 24
Houston	2	16	February 14
Los Angeles	7	8	February 8-24
Miami	4	29	February 28 & 29
New York City	5	23	March 13 & 14
Philadelphia	7	19	February 17 & 18
San Francisco	6	42	February 15 & 16
San Juan	6	32	March 6 & 7
Washington D.C.	7	27	March 7 & 8
Total	60	299	

Although just two JSI team members participated in each site visit and the corresponding discussion, 10 staff members were mobilized to participate in the site visits overall. This enabled JSI to accomplish most of the data collection within a four-week period. Each team member participated in one to three site visits, and most participated in at least two. This helped facilitate comparisons across sites. The

team included three Spanish-speakers, one of whom participated in the Miami site visit, and two of whom participated in the San Juan site visit.

All groups were facilitated using the guide developed for the local partner discussions (see *Appendix D*). At each site, the two participating JSI team members rotated responsibility for facilitating and taking notes across the discussion groups. For all discussions, the facilitator read the introductory script (which described the purpose of the evaluation and discussion, as well as confidentiality), verified willingness to participate, and confirmed consent to record the discussion. Each discussion group lasted 60-120 minutes; audio was recorded and notes were taken by one member of the team.

At the conclusion of each site visit, the participating JSI team members developed a list of key themes identified during the visit. Within one week of the visit, the team members prepared a complete site visit summary, describing the discussions and meetings held and the main themes identified, including supporting quotes and examples. Detailed notes were also prepared for each meeting held, based on the notes taken by the JSI staff member. Audio recordings were uploaded to JSI's secure servers and accessed as needed to clarify notes and/or verify quotes. The audio recordings of the discussion held in San Juan, Puerto Rico were transcribed and translated from Spanish to English.

Each site visit team also identified and prepared a brief written summary of a "success" from each jurisdiction. Because confidentiality had been assured to all participants, the JSI site coordinator for each jurisdiction was responsible for obtaining permission to share the "success" and identify the jurisdiction in the final report.

Analysis. Standard qualitative techniques were used to analyze the information gathered from the local partner discussions to identify key themes and concepts. First, all team members who participated in the site visits reviewed the 12 site visit summaries. In addition, each team member was required to review the notes from their own site visit(s) and the notes from two others sites assigned by the project director.

Using a modified nominal group technique,¹² the JSI evaluation team held a half-day meeting to identify "emergent" themes and sub-themes. To facilitate discussion, these themes were grouped initially into the five "domains" identified in the evaluation framework described previously (see Figure 3), including planning, resources, services, communication, and data. An additional category "context" was created to capture issues related to national or local trends or other factors that affected local activities, but were not necessarily the result of 12CP.

A second half-day meeting was held to validate, refine, and finalize the list of themes and sub-themes. Team members were then assigned to write a narrative for the themes, using notes from the team discussions, the site visit summaries, and the discussion group notes. Notes for all discussion groups were combined into one digital file, enabling automated searches for key words and concepts and for identification of examples and quotes. A third half-day meeting was held to review and refine the draft narratives for each theme and to provide further insights based on site visit experiences.

This team-based process is complex and can be more time consuming than processes that rely more heavily on automated, computer-based methods. Nonetheless, this process was chosen after careful

¹² Nominal group technique is a facilitator-led process for generating ideas that supports both individual input and collective decision-making.

consideration for several reasons. First, it enabled the richness of the experiences to be articulated and fully explored by all members of team who participated in the data collection activities. Second, it helped maximize the strengths of qualitative analysis by allowing the team to discuss and identify, through an iterative process, the meanings, context, processes, and explanations that they identified and observed. Third, it helped address one of the key challenges of qualitative analysis – the validity of the results. Agreement among investigators or “triangulation through multiple analysts” is a common method for increasing the likelihood that the analysis results are valid.¹³

FINDINGS

Based on the site visits and discussions held with the local partners, JSI has identified seven themes in response to the evaluation question that guided this evaluation (see Figure 3). Each theme is described below, organized around corresponding sub-themes. There is some unavoidable overlap among themes, and cross-references are provided throughout. In addition, “successes” from the 12 jurisdictions are highlighted within corresponding themes.

Theme 1 Understanding of the 12 CP and its goals varied across and within jurisdictions.

Understanding of the 12CP varied by role and position of the stakeholder. Similar to the findings from the Federal partner data collection, there was variation in the understanding of the 12CP among local partners. Health department staff members were more informed about 12CP, though knowledge varied across health department programs. In most jurisdictions, HIV program staff were more familiar with the 12CP than behavioral health program staff. Members of the community (e.g., representatives of community health centers, CBOs, and universities, and PLWH) were generally less informed about the 12CP, particularly those that were less engaged in local planning activities.

12CP was perceived primarily as a Federal initiative. In general, most participants described 12CP as a Federal project. Some described it specifically as an HHS response to operationalize the fourth goal of the NHAS. In the words of one participant, 12CP is “a programmatic manifestation of the fourth goal of the NHAS.” Others described 12CP as having a role in coordinating Federal agencies like CDC, HRSA, and SAMHSA to streamline resources for greater impact on the HIV epidemic in jurisdictions most affected by HIV. According to one participant, the 12CP is “the umbrella that holds all the Federal partners together.” Among some participants, there was also an acknowledgement that 12CP was a demonstration project. But this had both positive and negative connotations. For example, some participants described 12CP as an unfunded pilot project, while others noted its potential benefits. For example, one participant said 12CP provides “a roadmap to find the best approach to the HIV epidemic” and “an opportunity to create a model for other cities.” Another participant said that 12CP was a “demonstration project to bring to scale HIV prevention and care projects and to prove a concept – using a combination of HIV programing, test and treat models, and using scarce resources more efficiently.”

¹³ Ryan, G. and H.R. Bernard. 2003. Techniques to identify themes. *Field Methods*, 15(1): 85-109.

Because the 12CP built upon and resembled ECHPP in its focus on the 12 jurisdictions, participants said that it was difficult initially to distinguish between the two initiatives. Jurisdictions were most familiar with ECHPP because they had responded to a CDC FOA that had objectives and deliverables and supported a designated local coordinator. Some described ECHPP as part of 12CP or as a mechanism for making 12CP successful.

Figure 5: Quotes Reflecting Common Perceptions of 12CP

- *“A programmatic manifestation of the 4th goal of NHAS”*
- *“The umbrella that holds all the Federal partners together”*
- *“A road map”*
- *“An opportunity to create a model for other cities”*
- *“A demonstration project”*
- *“A philosophy without an implementation plan”*

12CP has encouraged new partnerships. A number of jurisdictions described 12CP as improving (or potentially improving) CCI by either re-engaging or facilitating the involvement of new local and Federal partners in local activities. Some participants expressed appreciation for HHS leadership and access to Federal partners beyond CDC, such as the VA or NIH. Some participants also perceived 12CP as an effort to dismantle the historic boundaries between care and prevention. As an example, San Juan, Puerto Rico has seen new partnerships resulting from NHAS, ECHPP, and 12CP. There were new partnerships established with University of Puerto Rico, Ponce Medical School, Department of Housing, Department of Corrections, and Federally-funded CBOs. For most of these partners, collaborations have involved efforts to build awareness of ECHPP, NHAS, and 12CP. The strongest collaboration was between prevention and Ryan White programs, which have made strides in linkage to care and data sharing.

Overall, discussions with local partners highlighted the critical role of effective communication in supporting CCI activities. Many local partners noted recent improvements in communication with Federal partners, as well as opportunities for further enhancements. Several communication-related sub-themes are discussed below.

Open communication between local and Federal partners is welcome and appreciated. Participants across the jurisdictions emphasized that the quality of communication among and between Federal staff, local health departments, and HIV/AIDS service providers has an impact on CCI efforts. Participants in several jurisdictions expressed appreciation for recent opportunities to talk directly with HHS staff and other 12CP partners to support local activities.

Reflecting some of the confusion highlighted in Theme 1, some participants reported that the goals and objectives of Federal initiatives are not always communicated effectively to the local level. As such, participants expressed a range of needs for ongoing communication from Federal partners about 12CP activities, for both health department and community planning stakeholders (see Figure 6). Specifically, participants identified a need for improved “vertical” communication between Federal and local partners so that local partners are aware of the full range of HIV resources in their areas. For example, health department staff in one jurisdiction mentioned that they were surprised to learn about a CDC, directly-funded HIV testing initiative in their city for MSM of color. They noted the health department also has HIV testing requirements as part of its CDC’s funding, and the lack of information about other initiatives can affect their ability to prevent duplication and achieve their goals. Other participants were not aware of HRSA’s directly-funded initiatives in their jurisdictions (e.g., *Ask, Screen, and Intervene* programs funded in some Ryan White Part C-funded clinics). Participants stressed the importance of knowing what was funded in their jurisdictions to minimize duplication and promote efficient use of resources. This point was emphasized by larger jurisdictions, where numerous funding mechanisms can make CCI challenging. It was suggested that there be routine federal reporting of grant funding to local jurisdictions that would avoid gaps in knowledge with respect to local resources.

Figure 6: Communication Needs

- Full information on all jurisdictional HIV resources
- Opportunities to talk directly with HHS leadership
- Guidance from Federal partners on CCI approaches
- Routine updates on Federal CCI activities

Involvement in local CCI efforts has varied across Federal partners. As noted in Theme 1, participants said that some Federal partners have been more involved in local 12CP efforts than others. Federal programs administered in the jurisdictions, that have not typically been engaged in local HIV response (e.g., WIC, SNAP, CMS, and VA), can play an increased role in supporting local CCI. Variability of partner engagement in local activities was a recurring theme, and is described in more detail in Theme 3.

Local community involvement in decisions about the use of Federal HIV prevention and care funds has been a hallmark of the US response to HIV. This involvement was further encouraged by the passage of the Ryan White HIV/AIDS Program legislation in 1990 and the introduction of community planning requirements by CDC in 1994. Local community planning bodies, typically referred to as community and/or prevention planning groups (for HIV prevention), and planning councils (for HIV care) have included representatives from service providers, PLWH or those at risk, and other key stakeholders. These planning bodies have worked together with state and local health departments to identify unmet need; analyze epidemiological and service utilization data for effective targeting of resources; identify and select effective interventions and services; and set priorities for allocation of resources.

As a result of NHAS, ECHPP, and 12CP, jurisdictions have implemented a variety of changes in HIV planning. In fact, community planning initiatives were most frequently cited by jurisdictions as evidence of CCI at the local level. Several subthemes related to community planning were identified and are described below.

Community planning activities across the 12 jurisdictions reflect a continuum of CCI efforts to bridge care and prevention. Jurisdictions reported a range of activities that demonstrated a commitment to enhancing collaborative, integrated approaches to community planning to address HIV prevention and care issues. Participants reported that these efforts reflect local commitment to bridging historic gaps between prevention and care as well as reducing duplication of effort among those involved in a variety of community planning activities.

All jurisdictions reported progress toward some form of joint planning across HIV prevention, care, and/or related services though not all jurisdictions attribute this to 12CP. Most jurisdictions have developed (or were already working on) a single, comprehensive HIV prevention and care plan. In this approach, the local prevention planning group (PPG) and Ryan White Planning Council (PC) worked together to assess community need, identify priorities, and develop a plan. In one jurisdiction, the PPG and PC also assumed joint responsibility for the plan's implementation, made easier by the development of an "electronic connector" linking care and prevention databases.

Participants in many jurisdictions stressed that the process of developing integrated, comprehensive HIV plans had significance beyond the written documents. According to one participant, the new comprehensive plan "isn't just an integrated document -- it's truly about a coordinated, integrated planning process." A PPG member in one jurisdiction said that the goal of the local process was to take "prevention, care, and housing – three different footprints -- and aim for seamless care." And participants in another jurisdiction described the development of a "super committee" that included representatives from the PPG and PC, with the goal of enhancing information sharing and planning activities across prevention and care.

The new comprehensive plan "isn't just an integrated document – it's truly about a coordinated, integrated, planning process."

Participants noted a variety of factors have encouraged integration or other CCI activities related to community planning. The most common facilitators are described in Figure 7. NHAS, 12CP, and ECHPP have provided a framework for these efforts; while the increased Federal focus on the integration of HIV care and prevention have been a catalyst. As one participant said “It was the recent HRSA focus on early intervention services that spurred us to integrate the groups finally. That was the last sign . . .” Lastly, the economic recession has strained local budgets and made it harder to support multiple distinct planning groups.

Figure 7: Community Planning CCI Facilitators

- **NHAS and 12CP:** Both have contributed to enhancing collaborative community planning activities. “When you think about the NHAS and 12 Cities, it gave you this blueprint -- this is what is happening out there. Let’s shape our efforts around the NHAS goals . . . the NHAS gives us this focus.”
- **Care and Prevention Integration:** The renewed emphasis on HIV testing, CDC’s high impact prevention strategy, and HRSA’s early intervention efforts were all cited as catalysts for CCI. “Care was beginning to look more like prevention, and prevention was starting to look like care.”
- **ECHPP:** The extensive planning process required by ECHPP encouraged comprehensive care and prevention planning.

For those jurisdictions that had developed integrated local planning groups, it was clear that it was a complex process that required substantial effort and time (and in some cases, assistance from external consultants). In some jurisdictions,

however, integration either was not possible or not desirable. For example, in one jurisdiction, participants said that integration of the PPG and PC was impossible, because PC members were technically members of a county commission (a local political entity), while members of the PPG served the local city. In another jurisdiction, participants argued that a single, integrated planning body should not necessarily be the “gold standard” for all locations, particularly if integrated planning can be accomplished through effective partnerships among existing planning groups.

Jurisdictions noted additional challenges to integrated planning efforts. Though not insurmountable, these issues were barriers to CCI, and may serve as potential “cautions” for replication of similar efforts beyond the 12 jurisdictions. These challenges included the following:

- *Different mandates and resources:* Many jurisdictions reported that an impediment to structural integration of PCs and PPGs were the disparate roles, functions, and requirements associated with each of these planning bodies. PCs were described as having greater authority, as well as significantly more resources than the PPGs. In New York City, home of the largest HIV/AIDS epidemic in the nation, an attempted merger of prevention and care proved unworkable. As one participant put it, “In the past there was an effort to merge the two bodies. With governmental co-chairs of both, it still didn’t result in an exchange at the planning level. Then we tried an Executive Committee of the two-- it fizzled out. ... When you start the conversation -- because the HRSA budget is so big -- the conversation immediately goes to care given the budget discrepancies.”
- *Different service areas:* PCs and PPGs have distinct geographic service areas for which they are responsible. PPGs may plan for a city or state region, while PCs plan for an eligible metropolitan area that may span multiple cities, counties, and even states. In addition, consumers cross geographic boundaries to access services.
- *Membership capacities:* HIV planning requires knowledge and skills about a wide spectrum of HIV-related needs, issues and strategies. Member capacities vary within and across PC and PPGs. “After

the integrated planning body begins to meet, we are going to need TA to build skills . . . to level the knowledge across the different groups.”

- *Time commitment:* Active participation in community planning takes time, and can be a challenge for providers who are grappling with resource constraints and service delivery priorities, and for consumers and other community representatives who are dealing with health care issues and other personal and professional commitments. “Bringing people to the planning table has been really hard because people do not have the time. Coming to the table to plan would mean giving up vital service provision.”

New partners have joined community planning efforts. Participants reported that new partners have become involved in local community planning activities, encouraged in part by NHAS, 12CP, and health care reform. Examples of new partners included health care providers (e.g., hospitals and community health centers); service providers focused on aging and other chronic diseases; and local schools and organizations involved in HIV research (e.g., CFAR). In Houston, the process to develop an integrated plan resulted in new partners being invited to the table as part of the planning process. Some of the new players include hospital systems, associations of FQHC, and corrections programs, among others. It was noted that past HIV plans have involved about 20-25 agencies. This time, it has included about 60.

“During our prior HIV plan, we had 20-25 organizations that provided input. This time, we have had 60 agencies involved.”

Participants in another jurisdiction described a recent restructuring of the PPG to incorporate new partners. Six new members were appointed representing primary care, mental health, and substance abuse services, STD services, correctional health, housing, and the local HIV care council.

In some locations, the recent SAMHSA MAI-TCE funding opportunity was noted for encouraging the participation of mental health and substance abuse service providers in planning activities. In addition, a few jurisdictions highlighted the role of the Regional HHS Office as a partner in local planning activities. In one jurisdiction, the regional lead has played a role in organizing regional meetings focused on NHAS and HIV testing, to promote collaborative testing events throughout the jurisdiction. As noted in the previous section, regional meetings have now occurred in all Regions and have provided an increased coordination and cooperation among a range of Federal program representatives at the local level.

In spite of these successes, some jurisdictions noted challenges with engaging pivotal partners. As one community planner participant noted, “It seems that everyone didn’t get the same memo” from their Federal counterparts. He continued “If CDC or HRSA tells us we have to do something, we may grumble, but we do it. It doesn’t appear that other programs are getting that same message [from their Federal counterparts].” For example, while some jurisdictions described the involvement of housing services providers, others cited challenges in getting local HOPWA representatives to participate in community planning or related activities. In a few locations, participants said that it was more challenging to consistently engage partners from VA, corrections, and CMS in collaborative planning activities.

Stakeholders noted that CMS is a key partner to engage in local planning activities, particularly in light of health care reforms in the Affordable Care Act, and the pivotal role CMS will play in reimbursement of HIV testing and other services. Describing a successful working relationship with CMS, one participant in Chicago said, “We are working with the Medicaid office and clients to share information from/with Medicaid. . . We found the one HIV client who was expending millions of dollars a year in Medicaid

services and worked to get her important housing and case management services to get her stabilized and significantly reduce Medicaid expenditures. This is a great example of using data across Federal funders to inform services and save costs.”

Additionally, a couple of sites are looking to local Medicaid offices as potential sources of information with respect to HIV testing information. In Washington DC, planning is underway to improve Medicaid payment for substance abuse services, facilitating greater access to services.

Data are driving planning efforts in new ways. While likely not a direct result of the 12CP, many jurisdictions described the increased use of data for planning purposes, and the important role of data in targeting resources to maximize impact. In some jurisdictions, the use of geographic information systems (GIS) to map surveillance data has enhanced community planning activities, making it possible to target resources more effectively to areas and populations of greatest need. In addition, many jurisdictions reported success in developing integrated, cross-matched disease registries, allowing planners to develop integrated program initiatives for HIV, STD, and hepatitis testing and screening. The use of viral load data has made it possible for some jurisdictions with this capacity to develop programs that re-engage consumers in primary medical care. Several jurisdictions have also used data modeling techniques to target resources for effective interventions with maximum impact. The role of data in local decisions about HIV resources is explored further in Theme 6.

Access to information about all HIV resources and services in the jurisdiction can enhance community planning. As noted in Theme 2, communication between Federal and local partners was described as a key factor in successful CCI, including ensuring information on the range of HIV resources available in local jurisdictions. This finding was also noted as important for effective HIV community planning. Although some improvements in information access were noted, participants reported some gaps in knowledge about the range of HIV resources available in their service areas. Access to CMS expenditures, for example, would help target HIV testing resources and prevent duplication. Similarly, more information about CDC’s directly-funded initiatives could be useful in coordinating local responses, as would CBO participation in local planning efforts. As one participant lamented, “[it is] no longer a contractual requirement [for these organizations] to participate in community planning. We loved that [previous requirement] . . . it was an opportunity to combine what the [Department of Health] is doing and the CDC . . . We could have a fuller landscape of what is happening . . . in the city . . . It now makes it very hard for us to bring these organizations to the table. We can’t coordinate.”

Lack of Federal guidance can impede planning. Participants expressed concerns about the delayed release of CDC’s guidance for HIV prevention planning. In some jurisdictions, participants said that they moved ahead with developing an integrated HIV plan and hoped it would meet CDC’s expectations. One participant suggested that HRSA and CDC should develop joint guidance for an integrated, comprehensive HIV plan, and noted that such integrated guidance already exists for developing epidemiological profiles. In addition to the impact on plan development, other participants expressed concern about the future role of community input. “The PPG is waiting for the CDC community planning guidance. They do not know exactly what role the membership is to assume . . . they have some vague understanding from the application that they may serve in a more advisory capacity than they have in the past . . . the environment [says to them] that their voice is no longer necessary. All they want to hear is whether what [they] have put together makes sense. This makes it difficult to keep the momentum going.”

Note: Now that the new CDC planning guidance has been released (July 2012), it clearly supports integrated planning across HIV prevention, HIV care and other Federal funding streams. Objective 2 clearly states, “By the end of the project year, the HPG [HIV Planning Group] will develop an engagement process and the HD will implement a collaborative engagement process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations—particularly those disproportionately affected by HIV across states, jurisdictions, and tribal areas.”¹⁴

Theme 4

12 CP has reinforced and provided a rationale for jurisdictional progress toward integration of HIV care and prevention services.

Data collection with local partners indicates that there have been efforts to integrate prevention and care services in all 12 jurisdictions. Some were initiated in conjunction with the NHAS, ECHPP, and 12 Cities, while others have been underway for some time. In a few jurisdictions, CCI efforts started well before CDC’s PCSI, with some going back as far as the late 1990s. Attributing CCI of HIV prevention and care programs to any single initiative is difficult, if not impossible. However, most jurisdictions acknowledged that the Federal emphasis on CCI, as expressed through 12CP, has provided additional support for their local CCI efforts.

Two sub-themes emerged related to this theme, including: (1) enhancement and integration of prevention and care services; and (2) changing relationships between CBOs and clinical care sites. These are described more below.

Some HIV services have been enhanced and integrated. There have been efforts in all jurisdictions to enhance HIV services and promote greater CCI across HIV prevention and care services. In some jurisdictions, integration has occurred at the health department level, and has involved the merging of different programs, bureaus, or units focused on HIV care, HIV prevention, STDs, hepatitis, and/or TB.

In addition to these administrative efforts, participants also described various efforts to integrate services for PLWH or those at risk for HIV. These activities focused primarily on HIV testing, linkage to care, and prevention services for PLWH (“prevention with positives”). Each of these is described below:

- ***HIV Testing:*** Various jurisdictions have used regional or jurisdiction-wide approaches to increase, coordinate, and/or more effectively target HIV testing. Among these jurisdictions, most were able to cite an increase in the number of HIV tests conducted, while others described coordinated strategies to target testing resources more effectively. Many sites used surveillance data to identify geographic areas or populations at high risk for HIV (see Successes below), and to target resources accordingly. New relationships between prevention and surveillance programs, as well as changes to consent forms, were helping to facilitate these new uses of data.

¹⁴ This guidance was released in July, 2012, during the preparation of this report. See <http://www.uchaps.org/assets/HIVPlanningGuidance2012.pdf>

Changes in testing laws in at least one-half of the 12 jurisdictions have facilitated increased HIV testing in various service settings. These laws have followed CDC guidance and have reduced barriers by eliminating requirements for pre-test counseling, and replacing written consent prior to testing with opt-out provisions. See, for example, California Health and Safety Code Section 120990. A complete listing of state HIV testing laws may be found on the National HIV/AIDS Clinicians' Consultation Center website.¹⁵ In at least two jurisdictions, CFAR sites have supported improvements in testing initiatives in clinical settings. However, in a minority of jurisdictions, HIV testing efforts have been constrained by reductions or shifts in funding. As resources have generally remained level in these jurisdictions, some smaller organizations have found it difficult to continue providing HIV testing services.

- *Linkage to care.* Increased efforts to link PLWH to care were identified in many jurisdictions as an example of CCI between HIV care and prevention services. Almost all of the jurisdictions cited examples of new or enhanced initiatives to improve processes for linking people to care. Many jurisdictions have been involved with CDC initiatives such as Anti-Retroviral Treatment and Access to Services (ARTAS) or PCSI, which have also facilitated linkage to care. Several jurisdictions were using resources to ensure that “warm handoffs” of newly positive individuals to either a case manager or medical provider following delivery of positive test results. In at least two jurisdictions, linkage to care strategies were initiated immediately upon receipt of a positive result without waiting for a confirmatory test.

In other jurisdictions, linkage to care staff immediately follow up with newly positive individuals, by telephone or in person, to assist with transition to care. In addition, many of the same linkage to care resources were being used to support efforts to identify and re-connect HIV-positive individuals who have fallen out of care. In another jurisdiction, community health workers were being used to follow-up with individuals who test positive and bring them into medical care. As one provider described it, “Anyone with an HIV positive test automatically becomes a [linkage to care] patient or client. They [the testers] have a MOU with the Surveillance Unit to share data. They submit all data of persons recently diagnosed to surveillance. Then surveillance submits a report to let [linkage to care] providers know if it’s an existing or new case.”

In San Francisco, the Department of Public Health (SFDPH) has initiated a program called “Linkage Integration Navigation and Comprehensive Services” (LINCS) to improve linkage to and maintenance in care. LINCS is both an umbrella and a safety net with SFDPH staff specifically trained to identify new cases from surveillance and Public Health Lab data, and to conduct follow-up to ensure PLWH get into and/or remain in care.

- *Prevention with Positives.* Integration of HIV care and prevention was also evident in jurisdictional efforts to provide HIV prevention services for PLWH. In many jurisdictions, prevention has assumed a greater role in clinical settings. The CDC’s inclusion of prevention with positives as a core service in its recent health department FOA has further supported these services.

The SFDPH also created “collaboratives” of providers of prevention with positives and locally-funded syringe access services, with the goal of improving coordination, eliminating duplication, addressing service gaps. The SFDPH has sought to improve collaboration by indicating to community-based

¹⁵ http://www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws

providers that they are not “overly focused on units of service.” In addition SFDPH has adopted the technique known as “technology of participation” to ensure equity and parity among stakeholders.

There was a perceived need for CBOs to merge with clinical providers and concern about the impact of these changes. Increased integration of HIV prevention and care services has been accompanied by a concomitant perception among some participants that the work of CBOs has been devalued or defunded. This perception was related in part to the increased focus on HIV testing, linkage to care, and incorporation of HIV prevention services within clinical care sites. Across the 12 jurisdictions, a number of participants expressed concerns about the sustainability of CBOs and AIDS service organizations (ASOs), as community-based approaches are replaced by clinical or clinic-based services. Almost every jurisdiction reported closures and/or mergers of ASOs or CBOs. As one representative put it, “If groups haven’t already merged, the train has left the station.”

Some participants expressed concern about the impact of this trend, including the potential negative effect on smaller CBOs that serve transgender people, gay and bisexual men of color, homeless individuals, and other marginalized populations. In one jurisdiction, some smaller organizations were required to merge with larger ASOs in order to receive funding through the local health department. And in some cases, participants reported that larger ASOs were confronting the possibility that if they do not provide services in a clinical context, it could become difficult to maintain independent services. Some jurisdictions reported that many of the functions traditionally provided by these types of organizations were now being supplanted by the linkage-to-care programs, medical case management, HIV testing, and prevention with positive programs being run by health departments and/or incorporated into clinical settings.

“If groups haven’t already merged, the train has left the station.”

Theme 5

Funding mechanisms have encouraged CCI and new partnerships locally, and can be used more effectively to achieve the goals of the NHAS and 12 CP.

As noted in Theme 1, 12CP was primarily perceived by local jurisdictions as a Federal CCI initiative. However, through the local partner discussions, a theme emerged about the important role of funding mechanisms in translating Federal initiatives into local action. Several sub-themes were identified that help elaborate this theme, including: (1) the role of Federal funding opportunities as tools for communicating 12CP priorities, (2) the potential barriers to CCI that funding requirements can present, and (3) the role of local funding opportunities in supporting and guiding additional local CCI efforts.

Federal guidance for requests for proposals (RFPs), FOAs, and grants are significant tools for communicating 12CP priorities and encouraging CCI. Participants across many jurisdictions referenced the role of Federally-issued RFPs, FOAs, and other guidance in communicating Federal goals and priorities to local partners. CDC's ECHPP FOA and recent FOA for health department HIV prevention services, as well as HRSA/HAB's Ryan White grant applications were all cited as examples. Participants in many jurisdictions noted that the 12CP was not accompanied by a funding announcement or guidance, which, as described in Theme 1, resulted in varying levels of understanding and "ownership" of the project by local partners.

Nonetheless, local partners described a range of CCI activities that had been encouraged by recent RFPs and FOAs. In some cases, these were related to 12CP, and in others, they were not. Some jurisdictions described new collaborations and partnerships across funders/services (e.g., HIV testing and behavioral health; HIV testing and research), and nearly all jurisdictions noted the recent SAMHSA MAI-TCE funding opportunity, aimed at enhancing the integration of substance abuse and HIV services in the 12 jurisdictions. While some saw this as a 12CP initiative, others were less clear about the connection. Across jurisdictions, the initiative was described as an opportunity to both enhance HIV prevention, primary care, and behavioral health services, and address historic gaps in participation in prevention and care planning by representatives of Federally-funded substance abuse and mental health services.

One participant from a local health department observed that the NHAS and 12CP have "accelerated how Federal agencies talk to each other" and that the impact of this "cross talk" has been visible in various funding opportunities. Conversely, some participants expressed concern about the overall coordination of Federal funding directed at the 12 jurisdictions. One participant worried that the impact of 12CP was simply a redirection of funds to the 12 jurisdictions, but without solid coordination of those funds and initiatives at the Federal level.

NHAS and 12 CP "have accelerated how Federal agencies talk to each other."

In terms of the 12CP, many participants noted a lack of guidance about the project. Many expressed frustration at having to interpret the meaning of CCI on their own, and said they expected more concrete, action-oriented items from the 12CP. As one participant said, "We are stuck trying to figure it out." Another participant acknowledged that a lack of specific guidance has advantages and disadvantages. We were able to "build this model . . . [but it is also] limiting to creativity when you don't know where you should go . . . [and] you want to do it right."

Participants also acknowledged that CCI can be encouraged or required through a range of funding

opportunities, not necessarily only those tied specifically to 12CP. As one participant noted, “Funding requirements is one reason we are working together.” Several examples of how CCI can be encouraged through Federal funding opportunities included: (1) the requirement in the Ryan White Part A application (for grantees within the 12 jurisdictions) to describe involvement in ECHPP and 12CP activities; (2) requirements and funding support for CFAR grantees to reach out to local health departments (which resulted in increased HIV testing in at least one jurisdiction); and (3) a past CDC requirement that CBOs applying directly to CDC for HIV prevention funding get a letter of support from the local PPG.

Some participants, however, advocated for dedicated funding to support CCI and cautioned against additional requirements without additional resources. “We are expected to do more with less, especially with the unfunded mandate for collaboration. There are funding needs to create infrastructure changes.” Some participants suggested funding to support a local “CCI Coordinator” who could oversee various activities within the jurisdiction. Participants in several jurisdictions cited PCSI and ECHPP as examples of Federal opportunities that included funding resources to support integration of planning and programming across HIV, STD, TB, and viral hepatitis.

“We are expected to do more with less, especially with the unfunded mandate for collaboration. There are funding needs to create infrastructure changes.”

Federal funding requirements have been a barrier to local CCI. The scope, mechanism, and requirements of funding from Federal partners can also hinder local efforts at CCI. One participant expressed a concern shared across nearly all participants. We need “. . . more coordination among funding cycles, language, and to see CCI among Federal partners . . . When funding comes from different sources, with different mandates, and different restrictions, and targets different audiences it is very difficult to achieve [CCI].”

We need “. . . more coordination among funding cycles, language, and to see CCI among Federal partners . . . When funding comes from different sources, with different mandates, and different restrictions, and targets different audiences, it is very difficult to achieve [CCI].”

Many participants described how the lack of coordination across Federal funding streams results in duplicative, fragmented, and burdensome reporting requirements at the local level. Similarly, a lack of Federal coordination of application and reporting deadlines has further hindered CCI efforts. In this regard, one participant said: “Different deadlines coming from the feds are ‘killers.’ Everybody wants a coordinated response, but each player has a different deadline and it bogs down all the community partners and providers. And implementation plans based on different funding streams and what funds can go to what makes it very hard to integrate services. Applications for any of the grants are difficult because each one from each Federal partner has different definitions.”

Uncoordinated Federal funding also poses difficulties for CCI because of different eligibility criteria, definitions, and data collection and reporting requirements (discussed later in Theme #6). As one

“There’s a long road ahead for the process, and it’s improving, but we still think that there needs to be more communication at the Federal agency level.”

participant summarized, “There’s a long road ahead for the process and it’s improving, but we still think that there needs to be more communication at the Federal agency level, so that we, over here, have the guidelines as to what everyone should be working towards.”

In some cases, attempts at coordinated Federal funding were perceived as falling short of CCI goals. As noted above, the SAMHSA MAI-TCE opportunity was generally described by participants as an opportunity for new collaborations. However, several jurisdictions reported that it could have been more collaborative in design at the Federal level. Some participants said that the funds were clearly intended to promote collaboration, but the funding mechanism was administratively confusing. One participant said “. . . it sometimes appears that across Federal programs . . . they are not aware of what one agency is funding . . . It would be much easier if they talked to each other before releasing an RFP.”

Participants also described how uncoordinated funding requirements have significant impacts on service delivery. To comply with multiple Federal, state, and local funding requirements, a number of forms and other processes have to be completed by providers and consumers. One participant called these the “steep data requirements” of funders, which put an increasing burden on providers -- particularly clinical providers. ADAP recertification, and determining eligibility for a range of services all require time-intensive administrative processes. One participant described the burden this presents for clients:

“. . . the fact that when someone is navigating the system [they] can [only] access one service, but they have to wait until the next fiscal year starts in order to get a different service, and even the lengthy paperwork we ask of them . . . the Federal government asks for the same documentation from HRSA and its Parts, SAMHSA, and the participant. A participant that receives five or six services ends up submitting the same paperwork many times. For an HIV-positive person who already faces a barrier because of his condition, has a transportation barrier, has an access barrier, a barrier of other conditions that may exist, perhaps has a poverty barrier and medical coverage, can get grants for some services but not others. Besides getting care, they have to make time to bring all the lab tests to all the case managers, in order to be eligible to receive the service.”

Local funding initiatives can guide CCI and new service delivery models. Increased Federal emphasis on HIV testing and linkage to care, for example, has changed the way some local jurisdictions procure services. One health department described implementing the spirit of 12 CP as part of a recent HIV testing RFP supported by CDC and HRSA funds. While there are different requirements across the two funders, the health department pooled funds to minimize duplication and expand HIV testing services in the jurisdiction. As part of the RFP, the health department encouraged partnerships between clinics and CBOs to enhance HIV testing; mandated use of a rapid HIV test to streamline efforts in clinical settings; and requested data on HIV testing conducted in health department-funded hospitals be made available to provide a more complete picture of testing in the community.

However, as noted above in Theme 4 (and later in Theme 6), CCI involving braided or pooled funding still requires disaggregation of data for reporting to Federal funders, which is a major disincentive for these kinds of local initiatives. “Relationships are coordinated, but the funding streams are not. There is coordination *within* funding streams, but different funding streams are not coordinated.” A participant in another jurisdiction summarized, “So we collaborate, but my guidelines tell me I can’t work like this.” Jurisdictions have come up with various ways to disaggregate data for reporting purposes, but these have been done on an ad hoc basis with no consistent guidance from Federal authorities.

The use of data is key to achieving the goals of the 12CP. Overall, the NHAS encouraged agencies to use data to guide planning, improve client outcomes, and maximizing the efficient use of resources. Participants across the jurisdictions described ways that the NHAS and 12CP have inspired creative, more efficient, and collaborative uses of data and data systems to target resources, reduce duplication, and monitor progress. They also outlined significant challenges with local data collection and reporting.

Jurisdictions are using surveillance data to plan and target resources. It was clear across the 12 jurisdictions that there has been an increased focus on the use of data for planning and decisions about how to use HIV resources. As one participant said, “The local providers are empowered by data.” Participants provided numerous examples of how data have been used locally to improve CCI of services. One jurisdiction formed a task force representing 13 agencies that developed strategies for targeting HIV testing and care resources. The taskforces used HIV testing data, graphs, and maps to monitor positivity rates, target services, and avoid duplication of testing efforts. The taskforce also created a monthly calendar for posting each agency’s HIV testing schedule, which has helped reduce duplication and “lessened the feelings of competition.”

A few jurisdictions reported the power of GIS as a planning and resource allocation tool. One jurisdiction, in conjunction with a state university, conducted spatial analyses to identify and address the prevention and care needs of certain populations and neighborhoods. Another jurisdiction described an effort to map high-risk and priority populations by zip code. Other jurisdictions used GIS to compare service delivery and population data to assess whether services were located in areas of greatest need. One health department participant described using GIS to identify “hot spots” in the city based on HIV incidence and mortality and to target HIV outreach efforts in these areas.

Finally, some participants said they needed help with more sophisticated data analyses, such as measuring and calculating community viral load. Participants in one jurisdiction said that these types of analyses would require enhancements to their surveillance staff capacity. Some jurisdictions reported that they had already requested technical assistance for more complex data modeling analyses.

Jurisdictions are coordinating and integrating data across systems. Some jurisdictions reported success in cross-matching HIV incidence data with other STD, case management, and service data and have been able to link clients with other parts of the care system (see Successes below). One jurisdiction reported the use of linked HIV and STD surveillance data systems to refer clients into care. PLWH diagnosed with an STD are identified through this system and linked to partner notification services and HIV clinical care as needed. This same jurisdiction has also been able to extract laboratory data on viral load and CD4 counts from HIV surveillance to pre-populate ADAP recertification requirements. This process does require individual patient consent.

In another jurisdiction, the city health department uses a weekly list of HIV-positive test results at publicly-funded testing sites and compares it to city HIV surveillance data to assess which clients are newly diagnosed. With this information, the health department has been able to target services: new positives are referred to partner services and known positives to HIV prevention services.

Federal HIV prevention and care data systems need to be better coordinated. As noted already in several themes above, some local partners have figured out how to integrate funding streams to create seamless or integrated systems of prevention and care, including STD and HIV services. However, Federal funders require them to report on what was accomplished with a specific funding stream. Such requirements necessitate disaggregation of data within integrated service delivery systems that use braided funding streams. Some participants suggested that Federal partners must figure out how to support such local efforts, and enable more “global” data reporting focused on activities and outcomes.

Because of the historic separation between various HIV and related services (created and reinforced by separate funding streams), and disparate and inconsistent funder reporting requirements (including measures of quality), many health department programs and service providers have developed program-specific data systems that are not compatible with each other. Not only has this affected the ability to use data for meaningful purposes, it has also been enormously inefficient, requiring data entry in multiple systems. In many jurisdictions, HIV prevention and care data systems are not linked or integrated, not to mention data systems for related housing or behavioral health services. However, several sites described efforts to build data “bridges” for their prevention and care systems, while others recognized the need for improved data systems, but identified a lack of funding as a barrier. In some jurisdictions, participants reported that partner agencies have been willing to share data to support planning and reporting needs. In one jurisdiction, a participant said that a Ryan White Part B colleague added variables in the Part B data system to meet a Part A colleague’s data needs.

Even in jurisdictions where publicly-funded HIV data systems were integrated, the challenge of gathering data from Medicaid, Medicare, and private insurers remained. One participant noted, for example, that “they can’t see the universe of tests being done.”

Figure 8: Non-Standard Terminology

Local partners reported a lack of consistent Federal definitions of the following terms:

- Routine testing
- Opt-out
- Newly positive
- Linkage to care
- Engagement in care
- Retention in care
- Late to care
- Disability

Lack of consistent definitions of terms and eligibility criteria across Federal funders impedes CCI efforts. Many jurisdictions said that inconsistencies in definitions of terms, data variables, and eligibility criteria created confusion and posed significant challenges for data collection and reporting (see Figure 8). Nearly all jurisdictions expressed frustration that Federal programs that share the same goals have such disparate definitions. One participant elaborated -- “There is also an inconsistency in definitions and interpretation of definitions. SSI and HUD have different disability definitions. HRSA and CDC have different definitions for linkage to, and engagement in, care. There are different guidelines for HIV testing (e.g., opt-in/opt-out).” Participants reported that this leads to more work for staff. One participant said, “Each Federal agency asks for the same information in slightly different ways, so too much staff time is spent disentangling and then reweaving all the information.” Some participants said that greater consistency and alignment would support smoother implementation of CCI across funders and local partners.

Note: In August 2012 HHS identified and defined a core set of indicators for HHS-funded HIV prevention, treatment and care services including: HIV positivity, late HIV diagnosis, linkage to HIV medical care, retention in HIV medical care, antiretroviral therapy among persons in HIV medical care, viral load suppression among persons in HIV medical care, and housing status.

CCI is not easy and requires time, staff, and clear communication. Once coordination and collaboration are established as principles of operation, integration of services and activities often becomes easier, and, in turn, more effective. Several sub-themes emerged from discussions about CCI among local partners, including: (1) CCI is not new, (2) it can be challenging, and (3) trust plays an important role.

CCI was already in place. Participants in all 12 jurisdictions reported that they were already operating with CCI as an organizing principle. They were unanimous in their appreciation for CCI's critical role in carrying out HIV prevention and care services. They also cited the NHAS and 12CP for underscoring the importance of CCI and referred to ECHPP and SAMHSA MAI/TCE as providing funding that supported staff to undertake CCI planning and activities. At the same time, jurisdictions cited HRSA and CDC's increased focus on prevention and care through the PCSI, EIIHA, and Expanded HIV Testing Initiatives as contributing to increases in CCI activities.

While some jurisdictions cited close working relationships among local HIV, TB, STD, and viral hepatitis programs, others have reorganized their health departments to integrate these divisions into one (as previously noted). Undoubtedly, these structures and the initiatives cited above strengthen the effect of CCI. One jurisdiction credited 12CP for validating the coordinated planning and CCI it has been doing for years and said that it now has the Federal "leverage" to continue these activities.

CCI can be challenging. Even with these additional CCI supports, decreases in funding at the state level and level funding for Federal HIV programs has created an "austere" fiscal environment. Many said that designating one person to be responsible for CCI activities would be an important step, but funding constraints made this unrealistic. Regional approaches may also be helpful. Several jurisdictions indicated that the responsibility for promoting CCI had fallen to the local health department's ECHPP coordinator. Within the context of 12CP, this coordinator had the onus of reaching out to less involved partners, such as Medicaid, VA, and IHS. One participant said that she has had to "go knocking on their doors" rather than the other way around.

In other jurisdictions, the PCSI coordinator has been the individual responsible for coordinating with other local programs. When these coordinators focus on 12CP CCI activities, they are, essentially, doing an additional job and not necessarily what they were funded to do. Yet, in one jurisdiction, the presence and skills of both an ECHPP and PCSI coordinator were noted as necessary for supporting CCI. One health department representative said, "It is kind of amazing how paying just one person full-time can make a difference in getting us to talk to each other." In several jurisdictions, HHS Regional Health Administrators have come to the table to assist with coordination.

Some jurisdictions remarked on CCI occurring in an environment of health reform. Federal mandates, competing priorities, and various policies, such as HIPAA, challenge jurisdictions' ability to increase CCI significantly. Once the Affordable Care Act is implemented, there will be impacts on HIV prevention and care generally and on the Ryan White Program and Medicaid specifically. Yet, as one health department participant put it, "It is hard to do CCI when the future of the system is not clear."

As already described, categorical funding and reporting on individual program achievements conflicts with CCI's inherent across-programs approach. Jurisdictions fund organizations to provide a range of HIV and related services to a wide-range of consumers. While trying to coordinate services with other HIV partners, they have also been confronting funding and reporting pressures. Finally, as providers have grappled with constraints on resources, they have also struggled with constraints on time. "Bringing people to the planning table has been really hard because people do not have the time. Coming to the table to plan would mean giving up vital service provision."

Trust is an important facilitator of CCI. Collaborating organizations benefit from being interdependent. Trust usually derives from interdependence based on either differing interests (complementarities) or on shared ones. Complementarity occurs when "one party has unique resources (skills, expertise, money) that another party needs or could benefit from (and vice versa).¹⁶ Nearly every jurisdiction said that development of trust takes time, but it is vital for building and sustaining CCI. Collaborative efforts have been successfully launched, building on historic and respectful relationships between health departments, CBOs, hospitals, and consumers. One jurisdiction highlighted the role of its AIDS Education and Training Center, an organization trusted by local stakeholders to be a neutral and objective facilitator for meetings that involving many local partners and complex issues.

In contrast, in several jurisdictions, CCI has suffered as a result of trust issues among local stakeholders. One participant indicated that writing a comprehensive plan for the jurisdiction had been going well, yet also described tension between care and prevention providers. He said, "The care folks are sucking up the domain of prevention," and suggested that a greater effort could have been made to bring all stakeholders together. Another jurisdiction indicated that many community stakeholders were invited to participate in planning activities and that agency representatives that did participate did not have any decision-making authority. This same jurisdiction's department of health continued to have an uneasy relationship with other health entities. This, in turn, has led community members to be distrustful of the health systems that were established to serve them. None of this fosters CCI.

Another jurisdiction representative said, "Relationships require trust We have reached out to agencies, but getting a meeting has been difficult. Change isn't easy for everyone if they don't see it going in the direction that they want." Finally, some jurisdictions mentioned that effective CCI could lead to merging of services or an organization giving up a service (or even disappearing entirely). Both changes were viewed as unwelcome, and having the potential to make some stakeholders distrustful and unwilling to participate in CCI activities.

¹⁶ Thomson, Ann M, James L Perry, and Theodore K Miller. 2007. Conceptualizing and Measuring Collaboration. *Journal of Public Administration and Theory*. Advance access, published December 1.

Figure 9: Summary of 12CP Themes, Progress, Facilitators, and Barriers

THEMES

1. Understanding of the 12CP and its goals varied across and within jurisdictions.
2. Ongoing communication between Federal and local partners is necessary to achieve 12CP goals.
3. All jurisdictions have taken steps to increase the coordination of HIV prevention and care planning in response to a range of initiatives, including 12CP.
4. 12CP has reinforced and provided a rationale for jurisdictional progress toward integration of HIV care and prevention services.
5. Funding mechanisms have encouraged CCI and new partnerships locally, and can be used more effectively to achieve the goals of the NHAS and 12CP.
6. Data are driving decision making in new ways, but data collection and reporting remain a significant challenge.
7. CCI is resource intensive, requiring time, staff, funding, communication, and support.

CCI PROGRESS*

- Integrated HIV planning
- New Federal and local partner participation in local activities
- Increased communication between Federal and local partners
- Increased access to some data (e.g., local HIV resources)
- Coordination and integration of some HIV prevention and care services
- Increased use of data to guide planning and decision making

CCI FACILITATORS

- HHS leadership
- Prior CCI-related initiatives (e.g., PCSI, ECHPP, EIIHA)
- Local leadership and structures that support coordination and de-emphasize competition
- New and existing local relationships
- Data sharing to effectively target services
- Development of trust through small successes
- A history of working together
- Funding to support CCI
- Integrated data systems for monitoring and reporting
- Access to information on HIV resources in local jurisdiction

BARRIERS TO CCI

- Lack of clarity about 12CP and local role
- 12CP not tied to funding or specific RFA
- Lack of coordination across Federal funding streams
- Political or administrative “boundaries”
- Different Federal statutory/legislative requirements
- Different Federal definitions of terms and criteria
- Variable involvement of local and Federal partners
- Disparate Federal and local reporting requirements
- Incompatible data systems
- National recession and state budget cuts leading to an under-resourced system
- Mastering a large, complicated system
- Time, resource constraints, and competing priorities
- Uncertainty about the future

* Achievements noted are related to 12CP and the CCI focus, but may not be attributable exclusively to 12CP.

Recommendations

Recommendations emerged throughout the process of analysis of findings from both interviews with Federal partners and local site visits. Throughout the process of developing the themes, it was noted when information within a theme was actually a recommendation or when a recommendation became apparent in the context of the issues related to a theme. Over the course of this evaluation, HHS staff and JSI staff have agreed that recommendations can be used to consider how this demonstration project can inform future CCI efforts. These recommendations are offered in the spirit of supporting such an effort.

Prior to offering recommendations, there are a series of questions for both HHS and local jurisdictions that emerged from the evaluation process. These questions may be equally helpful in framing next steps and developing a next phase in the effort to enact a more coordinated Federal response that is reflected in local jurisdictions.

Questions for HHS:

- What role could programmatic guidance and benchmarks have in assisting to clarify goals related to future CCI efforts?
- How can activities at the Federal level best be viewed through the lens of the needs of local (and state) jurisdictions?
- How can we best share information about Federally funded activities at the state and local and use that information to improve CCI?

Questions for local jurisdictions:

- To what extent have we coordinated or integrated our Federal funding streams in response to the HIV/AIDS epidemic?
- What steps can be taken to further coordinate these funding streams that would assist us in achieving both locally set priorities as well as the goals of the NHAS?
- What methods have been most effective to influence this coordination i.e. a staff person with responsibility, cross-program teams, development of logic model, etc.?
- How can we communicate clearly with our Federal liaisons (project officers, regional reps, etc.) regarding further actions required to support CCI at the local level?

In developing the following recommendations, it was agreed that it would be useful to connect them to the specific actions of the 12CP as set out in the HHS operational plan and summarized in the brief 12CP fact sheet. Thus each recommendation is tied to at least one of the major activities of the 12CP.

Recommendation 1: HHS should work to promote integration projects like 12CP and provide guidance to agencies on how to make any new programs “user friendly” to the jurisdictions. This includes utilizing existing advisory groups rather than starting new ones, keeping reporting to a minimum and ensuring the terminology and criteria (eligibility for services; allowable costs) are consistent.

Recommendation 2: Across the 12 jurisdictions, participants expressed concerns about the sustainability of CBOs and AIDS service organizations (ASOs), as community-based approaches are

perceived to be replaced by clinical or clinic-based services. More support is needed for CBOs that are exploring efforts to integrate clinical services or to merge with clinical providers. Increased integration of HIV prevention and care services has been accompanied by a concomitant perception among some participants that the work of CBOs has been devalued or defunded. This perception was related in part to the increased focus on HIV testing, linkage to care, and incorporation of HIV prevention services.

Recommendation 3: HHS should work with its agencies to identify a common guidance or framework for HIV prevention and care planning. This links to the 12CP activity to “Develop and apply lessons learned in these 12 jurisdictions to Federally funded activities in other jurisdictions, including creating technical guidance on the development of statewide plans, as called for in the NHAS.”

Recommendation 4: Consideration should be given to creating “HIV regional planning areas” that would act to clarify and consolidate jurisdictional issues with respect to Federal funding streams. Currently too many Federal funding streams in major metropolitan areas have different geographic footprints that lead to confusion and inequities with respect to access to many HIV services. Local jurisdictions should seek peer assistance in identifying models to support this integrated planning process.

Recommendation 5: HHS should encourage among its agencies a consistent practice of notifying state and local jurisdictions of directly funded services and programs within their catchment area.

Recommendation 6: HHS and its agencies should provide routine updates on its activities to improve coordination for HIV prevention, care and treatment so locals understand what progress is being made and how it affects them in terms of funding, reporting, and coordination of services.

Recommendation 7: HHS and its agencies should continue to encourage and strengthen movement toward an integrated and strategic approach to addressing the epidemic locally by coordinating reporting and funding periods and streamlining reporting requirements.

Recommendation 8: HHS should work with its agencies to provide common definitions for HIV-related terms and services.

Recommendation 9: HHS and its agencies should develop a formal process to identify and track TA needs with respect to coordination and encourage and support peer and other technical assistance.

Recommendation 10: Activities should be supported that identify successful changes to laws or regulations that allow data exchange to facilitate more efficient targeting of testing, linkage to care, and retention in care. This includes linkages between HIV prevention and care programs with HIV Surveillance, STD programs, Medicaid and Medicare, etc. Local jurisdictions should seek peer assistance to learn about best practices in integration of data systems to support efficient and effective HIV prevention and care services.

Recommendation 11: HHS should continue with the development and implementation of a small number of common indicators to measure progress in addressing the HIV epidemic. This effort is strongly supported and appreciated by the 12CP implementers at the local level.

Appendices

Appendix A: 12 Cities Project Evaluation Fact Sheet

Appendix B: Federal Partner Discussion Guide

Appendix C: Local Partner Site Visit Schedule

Appendix D: Local Partner Visit Discussion Guide

Appendix A: 12 Cities Project Evaluation Fact Sheet

Evaluation of the 12 Cities Project

FACT SHEET

Overview

In August 2011, the Department of Health and Human Services (HHS), Office of HIV/AIDS Policy (OHAP) contracted with John Snow, Inc. (JSI) to evaluate the implementation of the 12 Cities Project, a cornerstone of the HHS National HIV/AIDS Strategy Operational Plan. Building on CDC's Enhanced Comprehensive HIV Prevention Plan initiative, the 12 Cities Project addresses the fourth goal of the NHAS to improve the coordination, collaboration, and integration of Federally-funded HIV programs in the 12 jurisdictions that bear the highest AIDS burden in the country.

Purpose

This evaluation will assess the implementation of the 12 Cities Project to identify progress toward alignment of HIV resources for maximum impact on the HIV epidemic. This includes collaboration, coordination, and integration of planning, services, and funding (where feasible), as well as efforts to address gaps in services, develop standardized performance indicators, or streamline reporting requirements. In addition, this evaluation will identify any "lessons learned" that can be applied in other jurisdictions.

Evaluation Plan

Through a series of group and one-on-one discussions, this qualitative evaluation project will gather information from Federal partners and from state and local stakeholders in the jurisdictions. Discussions with the Federal Partners will focus on Federal efforts and activities. Discussions with stakeholders in the 12 cities will explore how those Federal activities have played out locally, and any local initiatives undertaken to help meet the objectives of The 12 Cities Project.

Site Visits to the 12 Cities Partners

Between November 2011 and February 2012, members of JSI's evaluation team will travel to each of the 12 cities for two-day site visits. During these visits, JSI will meet and hold discussions with state and local health department staff, community planners/participants (including providers and consumers), and other groups of state and local stakeholders that have had a role in the 12 Cities Project.

The discussions will focus on the following questions related to the coordination, collaboration, and integration of federally-funded HIV services:

- What progress, if any, has been made?
- What groups, organizations, or individuals have been involved?
- What factors have helped or hindered efforts?
- What technical assistance has been used or is needed?
- How is progress and change being monitored and measured?

Expectations for Participation in the Evaluation

Participation in the evaluation, including taking part in the discussions, is completely voluntary and will not affect your relationship with any federal funder. This evaluation is not intended to assess local performance, but rather to assess the 12 Cities Project overall. No information will be attributed to any participant by name. Specific jurisdictions may be cited to highlight best practices.

JSI is committed to conducting a high-quality evaluation that minimizes the burden on participants, especially the 12 Cities Partners. As such, **JSI will:**

- Maximize the use of existing data sources such as presentations and progress reports from the 12 Cities Partners to minimize the burden on sites of retelling information available through other means
- Provide logistical and planning leadership for the site visits and group discussions
- Work collaboratively and flexibly with the 12 Cities Partners to coordinate the site visits, responding to local needs, concerns, and existing or future activities

The participation of the 12 Cities Partners is key to the success of this project and it is expected that the **12 Cities Partners will:**

- Meet with JSI staff and participate fully in the evaluation, including the site visits
- Help JSI identify and recruit key stakeholders
- Share existing materials that may assist in the evaluation
- Be available after the site visits to answer follow up questions

Results

By August 2012, JSI will prepare a final evaluation report for OHAP that outlines key findings, common themes, unique and common challenges, and lessons learned that may be applied to the ongoing 12 Cities Project and to other jurisdictions. This report will then be made available to the 12 Cities Partners and the general public.

More Information

If you have any questions about the Evaluation of the 12 Cities Project, including its purpose, your involvement, or the methods, please contact one of the individuals below:

- Stewart Landers, JSI Project Director, slanders@jsi.com or 617.482.9485
- Vera Yakovchenko, OHAP, Vera.Yakovchenko@hhs.gov or 202.205.6606
- Dr. Andrew Forsyth, OHAP, Andrew.Forsyth@hhs.gov or 202.690.5560

About Us

Office of HIV/AIDS Policy (OHAP), within the Office of the Assistant Secretary for Health, advises the Assistant Secretary for Health and senior HHS officials on: the appropriate and timely implementation of HIV/AIDS policy; the establishment of priorities; and the implementation of HIV/AIDS programs, activities, and initiatives across other HHS health agencies. Learn more about OHAP at www.hhs.gov/ash/ohap.

John Snow, Inc. (JSI) is a public health and health care consulting company with nearly 30 years of HIV/AIDS experience, including monitoring and evaluation, research, and capacity building. JSI is headquartered in Boston with offices in seven other US cities including Atlanta; Burlington, VT; Concord, NH; Denver; Providence; San Francisco; and Washington, DC. Learn more about JSI at www.jsi.com.



Appendix B: Federal Partner Discussion Guide

Evaluation of the 12 Cities Project

Federal Partner Discussions

FACILITATOR'S GUIDE

Note about this tool

This tool is intended for use in discussions with Federal partners. Some discussions may be one-on-one, and others may be in groups. As such, the facilitator should adapt this tool as needed to reflect the format of the discussion.

Step 1: Welcome and Introduce Participants

Convene the group, welcome everyone, and ask participants and JSI staff to introduce themselves.

Step 2: Read Introductory Script (below)

“Thank you for joining us today for this discussion. Before we begin, I have some important information that I need to share with you. I will then answer any questions you have, and then we will start the discussion.

“The US Department of Health and Human Services, Office of HIV/AIDS Policy has contracted John Snow, Inc. to conduct an evaluation of the implementation of the 12 Cities Project, a cornerstone of the HHS National HIV/AIDS Strategy Operational Plan. Building on the CDC’s Enhanced Comprehensive HIV Prevention Plan (ECHPP) initiative, the 12 Cities Project addresses the 4th goal of the NHAS to improve the coordination, collaboration, and integration of Federally-funded HIV programs in the 12 jurisdictions that bear the highest AIDS burden in the country.

“The purpose of our discussion today is to learn from you about activities undertaken at the Federal level to help meet the objectives of the 12 Cities Project. This includes collaboration, coordination, and integration of planning, services, or funding (where feasible), as well as efforts to address gaps in services, develop standardized performance measures, or streamline reporting requirements. Specifically, we hope to learn more about any progress toward alignment of HIV resources for maximum impact on the HIV epidemic. By collaboration, coordination, and integration we mean [INSERT definition here].

“We will be holding discussions like this one with other Federal partners across various agencies. In addition, we are conducting site visits and holding discussions with local partners in each of the 12 jurisdictions, including health department staff, community planners or other participants, and any other key stakeholders involved in the local effort. Information you share with us will help us explore with the 12 jurisdictions how Federal activities and efforts have played out at the local level.

“As facilitator, I have a series of questions that I want to cover with you. This set of questions is the same for all of the groups we are conducting with Federal partners. It is likely that during our conversation, we will cover many of the questions without prompting; in other cases, we may need to ask you more pointed questions or probes. Nonetheless, we encourage you to share your thoughts and opinions openly and freely. But we also ask that you be respectful of the other participants’ opinions and time. At no time should you feel you have to answer a question.

“We will be taking notes and this discussion is being recorded to help ensure that we gather all of the information you share with us. Any information that you share with us today will not be attributed to you by name. However, activities will be attributed to specific Federal programs. We anticipate that our

Evaluation of the 12 Cities Project

discussion will last no longer than 90 minutes. If you feel uncomfortable or decide you no longer want to participate, you may leave at any time.

“The results of this discussion and others will be used to develop a written summary of Federal activities undertaken to achieve the goals of the 12 Cities Project and the 4th goal of the NHAS. This summary will be used to inform the discussions we have later this year with the local partners in the 12 jurisdictions. At the end of this project, a final report will be prepared that identifies key themes across jurisdictions, unique challenges and successes, and lessons learned that may be applied to the ongoing 12 Cities Project and to other jurisdictions. The summary of Federal activities will be incorporated into this report to provide important context for the evaluation. This report will be submitted to OHAP, and will be available to you and the general public.

“Before we begin, are there any questions about what I’ve just said, why we’re here, or what we are going to do today?”

Step 3: Answer Questions from Participants

Step 4: Begin Discussion with Questions Below

QUESTION #1: What is your understanding of the goals and purpose of the 12 Cities Project?

QUESTION #2: In what ways has the 12 Cities Project changed the way your agency works or implements programs?

Probe: Have there been any changes to funding opportunities and guidance, reporting requirements, collaborations, internal structures or processes, etc.?

QUESTION #3: Please describe some of the key successes of the 12 Cities Project to date.

Instruction to Facilitator: Explore federal, state, and/or local levels depending on responses.

QUESTION #4: From your perspective, what have been the biggest challenges for implementing the 12 Cities Project at the Federal level?

Probe: What have been some of the biggest challenges for implementing the 12 Cities Project at the local level? What has been most difficult for the jurisdictions?

QUESTION #5: If you look ahead two to four years from now, how will you know if the 12 Cities Project was successful? In other words, what would a successful 12 Cities Project look like?

Probe: Depending on response, explore explicit objectives of 12 Cities Project -- Better mapping of federal resources in MSAs? Reduction in gaps in program coverage/scale? Better coordination of services/funding? Common indicators? Streamlined reporting requirements?

QUESTION #6: What more can be done to enhance coordination, collaboration, and integration at the federal, state, and local levels?

Appendix C: Local Partner Site Visit Schedule

City	Dates of Visit	Groups Interviewed	
Atlanta	02/22/2012 – 02/23/2012	<ul style="list-style-type: none"> Georgia Department of Public Health: HIV Prevention and Care, Directors of HIV and STD Offices, STD Program Coordinator, Special Projects, Health Insurance Continuation, Contracts, ADAP/AICP, Adult Viral Hepatitis Prevention, Partner Services, Quality Management, HIV Nursing, Counseling and Testing Ryan White Part A Atlanta Harm Reduction AID Atlanta 	<ul style="list-style-type: none"> Fulton County Department of Health and Wellness Clayton County Board of Health DeKalb County Board of Health Cobb and Douglas Public Health Someone Cares Inc. Emory University Citywide Project
Baltimore	04/06/2012	<ul style="list-style-type: none"> Department of Health: STD Program, Infectious Disease Environmental Health ECHPP Evaluation IDEHA: Director, Deputy Director, Sexuality Minority Response Group/Outreach staff Ryan White Part B (HIV Prevention) Baltimore Health Services Council Project AIRS (HIV Housing/Homeless) Greater Baltimore HIV Planning Council 	<ul style="list-style-type: none"> OWELL/Co-chair of BRACK Johns Hopkins University Baltimore Black Pride IGS Regional Advisory Committees Local Health Departments/Federal Grantees: STD Prevention, HIV Prevention and Health Services, Baltimore County Health Department, Ryan White Grants Manager, Anne Arundel County Infectious Disease Control, Maryland HOPWA
Chicago	02/28/2012 – 02/29/2012	<ul style="list-style-type: none"> Illinois Department of Public Health (HIV/AIDS) US DHHS Regional Office Lead Lead funding agency for Cook County (Part B and some Part A) Director of HIV Monitoring and Evaluation Members of a community planning group 	<ul style="list-style-type: none"> Director of HIV Prevention Chicago Department of Public Health (HIV/STI Division): Assistant Commissioner, Epidemiology/Surveillance Director, Ryan White, Prevention, Housing, STI, CDC assignees
Dallas	02/22/2012 – 02/24/2012	<ul style="list-style-type: none"> Dallas County Health and Human Services surveillance staff (TB/HIV/STD epidemiology & surveillance, HIV/STD prevention & care) Department of State Health Services (HIV/STD prevention, ECHPP, development, HIV/STD branch chief) 	<ul style="list-style-type: none"> Ryan White Planning Council (grants management, planning council chair) Community Prevention and Intervention Unit School of Health Professions UT Southwest
Houston	02/14/2012	<ul style="list-style-type: none"> City and County Health Department (City Bureau of HIV/STD & Viral Hepatitis Chief, County Ryan White Grantee, city data, prevention and program staff) Ryan White Office support 	<ul style="list-style-type: none"> Part B funded organization (over 50 counties in eastern Texas) Ryan White Planning Council and Prevention Plan Group

City	Dates of Visit	Groups Interviewed	
Los Angeles	Series of Phone Calls	<ul style="list-style-type: none"> • HIV Prevention Planning Committee • UCHAPS • City of LA AIDS Coordinator's Office • LA Prevention Planning Committee • Office of AIDS Programs and Policy Research and Planning staff • Director and Program Manager of LA Gay and Lesbian Center 	<ul style="list-style-type: none"> • Past AIDS Coordinator for the City of LA • Director of Planning and Evaluation LA County • Executive Director of Commission on HIV (local Ryan White planning council) • Past Co-chair of HIV Prevention Planning Council
Miami	02/28/2012 – 02/29/2012	<ul style="list-style-type: none"> • Health Council of Florida • ECHPP Evaluation and Coordination (Florida Department of Health, Miami/Dade County Health Department) • Office of HIV/AIDS Program Coordinator • Early Intervention Unit • STD Program Consultant 	<ul style="list-style-type: none"> • Members of Miami Planning Council • Transgender work group • Miami/Dade County Public Schools (HIV/AIDS education program) • Borinquen • Group of consumers
New York City	03/13/2012 – 03/14/2012	<ul style="list-style-type: none"> • New York City Department of Health Bureau of HIV/AIDS (Prevention and Control, Epidemiology, HIV Testing, Care and Treatment, KNOWS testing initiative, Risk Reduction, SAMHSA Grant staff, Policy and Program Planning, Syringe Service, Harm Reduction, Condoms and Material Distribution, Prevention with Positives, Community Partnerships Groups, Online Outreach) • Community Planning Group 	
Philadelphia	02/17/2012 – 02/18/2012	<ul style="list-style-type: none"> • AIDS Activities Coordination Office • AIDS Education and Training Centers • Behavioral Health • Office of HIV Planning (Prevention Planning Group, Ryan White Planning Council) 	<ul style="list-style-type: none"> • Office of Addiction Services • Office on Housing and Community Development • Program Collaboration and Service Integration (Division of Disease Control)

City	Dates of Visit	Groups Interviewed	
San Francisco	02/15/2012 – 02/16/2012	<ul style="list-style-type: none"> • ECHPP Stakeholders : HIV Health Services, HOPWA, Jail Health, STD Prevention and Control, HIV Epidemiology, Community and Behavioral Health • Group of gay men • SFPDH HIV Prevention Section: Deputy Director/Director of Community Based Prevention Unit, Director of Clinical Prevention Unit, Linkage and Retention Coordinator, Director of Community Engagement and Policy Unit, Strategic Integration Coordinator, HIV Grants Coordinator • HIV Prevention Planning Council • HIV Health Services Planning Council 	<ul style="list-style-type: none"> • Prevention with Positives Providers: Shanti, STOP AIDS, Mission Neighborhood Health Center, Instituto Familiar de la Raza, Positive Health Program/UCSF, API Wellness Center • AIDS Healthcare Foundation • Larkin Street Youth Services • Glide • Tenderloin Health • Westside Community Services • San Francisco AIDS Foundation
San Juan	03/06/2012 – 03/07/2012	<ul style="list-style-type: none"> • Members of Puerto Rico Department of Health • HOPWA • Department of Family 	<ul style="list-style-type: none"> • Correctional Health Services Corporation • Members of the affected community • Community-based organizations
Washington D.C.	03/07/2012 – 03/08/2012	<ul style="list-style-type: none"> • Behavioral Health • HAHSTA • APRA • Department of Mental Health • Planning Council • HAHSTA Policy and Science Group 	<ul style="list-style-type: none"> • Director of Community Health Division/Director of Medical Adherence Unit • Community-based organizations • Prince George’s County: Chief for HIV Prevention and Care, Part A Grantee • Capacity Building & Community Outreach Bureau Chief

Appendix D: Local Partner Visit Discussion Guide

Evaluation of the 12 Cities Project

Stakeholder Discussion Groups

FACILITATOR'S GUIDE

Step 1: Welcome and Introduce Participants

Convene the group, welcome everyone, and ask participants and JSI staff to introduce themselves.

Step 2: Read Introductory Script (below)

“Thank you for joining us today for this discussion. Before we begin, I have some important information that I need to share with you. I will then answer any questions you have, and then we will start the discussion.

“The US Department of Health and Human Services, Office of HIV/AIDS Policy has asked John Snow, Inc. to conduct an evaluation of the implementation of the 12 Cities Project, a cornerstone of the HHS National HIV/AIDS Strategy Operational Plan. Building on the CDC’s Enhanced Comprehensive HIV Prevention Plan (ECHPP) initiative, the 12 Cities Project addresses the 4th goal of the NHAS to improve the coordination, collaboration, and integration of Federally-funded HIV programs in the 12 jurisdictions that bear the highest AIDS burden in the country.

“The purpose of our discussion today is to learn from you about how Federal 12 Cities Project activities have played out locally, as well as any local activities that have been undertaken to help meet the objectives of the 12 Cities Project. The evaluation is not intended to assess local performance, but rather to assess the 12 Cities Project overall.

“Specifically, we hope to learn more about any progress toward alignment of HIV resources for maximum impact on the HIV epidemic. This includes collaboration, coordination, and integration of planning, services, or funding (where feasible), as well as efforts to address gaps in services, develop standardized performance measures, or streamline reporting requirements. By collaboration, coordination, and integration we mean efforts to provide a more comprehensive and seamless approach to addressing the HIV epidemic in your jurisdiction that may involve your agency or organization and other people, agencies, or organizations.

“We will be holding discussion groups like this one in each of the 12 jurisdictions, with health department staff, community planners or other participants, and any other key stakeholders involved in the local effort. In addition, we have held discussions with Federal partners and have reviewed existing materials on activities related to the ECHPP project.

“Participation in this evaluation, including taking part in today’s discussion, is completely voluntary and will not affect your relationship with any federal funder. Any information that you share with us today will not be attributed to you by name. However, specific jurisdictions may be highlighted in the final report to help share best practices.

“As facilitator, I have a series of questions that I want to cover with you. This set of questions is the same for all of the groups we are conducting in the 12 jurisdictions. It is likely that during our conversation, we will cover many of the questions without prompting; in other cases, we may need to ask you more pointed questions or probes. Nonetheless, we encourage you to share your thoughts and

Evaluation of the 12 Cities Project

opinions openly and freely. But we also ask that you be respectful of the other participants' opinions and time. At no time should you feel you have to answer a question.

"We will be taking notes and recording this discussion to help ensure that we gather all of the information you share with us. We are not recording your names. We anticipate that our discussion will last no longer than two hours. We will take a short break after about one hour. If you feel uncomfortable or decide you no longer want to participate, you may leave at any time.

"The results of this discussion and others held in [INSERT CITY] will be used to develop a written summary for each jurisdiction. A draft of the summary for [INSERT CITY] will be shared with a key contact here for review to ensure accuracy. All summaries will then be analyzed as a group. A final report will be prepared that identifies key themes across jurisdictions, unique challenges and successes, and lessons learned that may be applied to the ongoing 12 Cities Project and to other jurisdictions. This report will be submitted to OHAP, and will be available to you and the general public.

"Before we begin, are there any questions about what I've just said, why we're here, or what we are going to do today?"

Step 3: Answer Questions from Participants

Step 4: Confirm Consent to Participate

"Based on what you've heard so far, I want to confirm that each of you consents to participate in today's discussion. Please say "YES" if you understand and wish to participate. If you no longer want to participate, you are free to leave before we begin.

"Are there any remaining questions?"

Step 4: Answer Questions (if needed)

Step 5: Turn on the Recorder

Step 6: Begin Discussion with Questions Below

Evaluation of the 12 Cities Project

QUESTION #1: What is your understanding of the goals and purpose of the 12 Cities Project?

QUESTION #2: What progress do you see, if any, in improving or increasing coordination, collaboration, and integration of federally funded HIV/AIDS prevention, treatment, and care services in [CITY NAME]?

Instruction to Interviewer – Explore each example of coordination, collaboration, or integration identified. Depending on what is identified, use the following probes to explore all topics of interest:

Probe: *Has there been any progress in coordination, collaboration, or integration of federally funded HIV/AIDS prevention, treatment, and care services? Funding streams or allocations? Service delivery? Communication? Data collection/reporting?*

Probe: *How have things changed in terms of coordination, collaboration, and integration since the implementation of the 12 Cities Project? Please identify any successes.*

QUESTION #3: What groups, organizations, or individuals have been involved in efforts to increase coordination, collaboration, and integration of federally funded HIV/AIDS prevention, treatment, and care services in [CITY NAME]?

Probe: *Were any key partnerships established?*

Probe: *Were there any key individuals or groups who have not been involved? Why?*

Probe: *Is there a group specifically charged with implementation of the 12 Cities Project? If yes, how often does it meet and what sectors are represented?*

QUESTION #4: What factors have helped or hindered efforts to improve or increase coordination, collaboration, and integration of federally funded HIV/AIDS prevention, treatment, and care services in [CITY NAME]?

Instruction to Interviewer – For each example of coordination, collaboration, or integration identified in Question #1, explore and discuss facilitators and barriers using the following:

Probe: *Earlier, you mentioned [INSERT EXAMPLE]. What factors helped or hindered that effort?*

QUESTION #5: What, if any, technical assistance (TA) did you receive to help improve or increase coordination, collaboration, and integration of federally funded HIV/AIDS prevention, treatment, and care services in [CITY NAME].

Probe: *Describe any TA you needed but could not get (or TA that you would find helpful now).*

QUESTION #6: How is progress on coordination, collaboration, and integration being monitored and how is change being measured?

Probe: *What challenges are you experiencing in monitoring and evaluating coordination, collaboration, and integration of HIV programs?*