

Part A: Introduction

How to Use This Document



How to Use this Document

The *2007-2009 Iowa Comprehensive HIV Plan* was prepared to be user-friendly and have useful material to guide providers in the development of their HIV prevention and care programming. The *Plan* is specifically designed to provide relevant information in one place.

Part A, including Chapters 1 and 2, will orient the reader to the document and provide an overview of the Community Planning Group (CPG). The remainder of the document will help to answer three core comprehensive planning questions:

- ***Where are we now?***
 - Chapter 3: HIV/AIDS and other STD's in Iowa
 - Chapter 4: Needs Assessment/Key Informant Interviews and Focus Groups
 - Chapter 5: Consumer Needs Assessment
 - Chapter 6: STD/HIV/AIDS Provider Services Survey
 - Chapter 7: Priority Populations for Prevention Activities
 - Chapter 8: Iowa Statewide Coordinated Statement of Need (ISCSN)
- ***Where do we want to be?***
 - Chapter 9: Prevention Recommendations and Conclusions
 - Chapter 10: Care Strategic Plan
- ***How will we get there?***
 - Chapter 11: Prevention Interventions
 - Chapter 12: Ryan White Title II Case Management Standards

This *Plan* can be used:

- In the development and implementation of HIV/AIDS prevention and care programs.
- To understand the role of behavioral and social sciences in HIV prevention and care.
- To ascertain what behavioral/social science model is most appropriate when developing prevention interventions.
- To respond to applications for funding.
- To understand historical foundations, cultural norms, and external factors and their relationship to HIV prevention and care activities.
- To demonstrate the importance of language and culture in HIV prevention and care.
- To advocate for services for those affected by, or at risk for, HIV.
- By community-based organizations and local health departments in their planning work.
- To help develop and support policies to improve prevention and care services for people living with or at risk of HIV/AIDS.

- As a public relations tool to inform communities in Iowa about the work of the IDPH and the CPG.
- As a training tool to promote an understanding of HIV prevention and care in Iowa.
- As a tool for students in public health, teaching, or other relevant disciplines at colleges and graduate schools.

Part A: Introduction

Chapter 1

Introduction to Planning



HIV/AIDS PREVENTION AND CARE COMMUNITY PLANNING

HIV community planning is an ongoing, comprehensive planning process that is intended to improve the effectiveness of state, local, and territorial health departments' HIV programs by strengthening the scientific basis, community relevance, and population or risk-based focus of prevention interventions and care services.

The 2007-2009 Comprehensive HIV Plan serves as a guide for HIV prevention and care services in the state of Iowa. This evidence-based planning process incorporates guidelines put forth by the Centers for Disease Control and Prevention (CDC) in the HIV Prevention and Community Planning Guidance, and the goals and responsibilities identified for Ryan White CARE Act grantees by the Human Resources and Services Administration (HRSA). The Iowa Department of Public Health (IDPH) is committed to developing and implementing a planning process that incorporates the views and perspectives of providers of HIV prevention and care services and of HIV-affected groups, for whom the programs are intended.

ORIGINS AND PURPOSE OF HIV PREVENTION COMMUNITY PLANNING

In 1993, the CDC directed states and localities that receive federal funding for HIV prevention to conduct a community planning process. HIV Prevention Community Planning was built around the following principles:

1. HIV prevention community planning reflects an open, candid, and participatory process in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
2. HIV prevention community planning is characterized by shared priority setting between health departments administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.

Priority setting accomplished through a community planning process produces programs that are responsive to high-priority, community-validated needs within defined populations. Persons at risk for HIV infection and persons with HIV infection play key roles in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate. HIV prevention programs developed with input from affected communities are likely to be successful in garnering the necessary public support for effective implementation and in preventing the transmission of HIV infection.

In 2003, the CDC set three major goals for HIV Prevention Community Planning. The three major goals are:

1. Community planning supports broad-based community participation in HIV prevention planning.
2. Community planning identifies priority HIV prevention needs (i.e., a set of priority target populations with specific interventions identified for each target population) in each jurisdiction.
3. Community planning ensures that HIV prevention resources target those priority populations and interventions set forth in the comprehensive HIV prevention plan.

Comprehensive Planning Process: Prevention

To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC expects Community Planning Groups (CPG)s to address the following *Guiding Principles of HIV Prevention Community Planning*:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
3. The community planning process must involve representatives of populations at greatest risk for HIV infection and persons living with HIV/AIDS (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion, and representation (often referred to as PIR).
 - *Parity* is defined as the ability of members to participate equally and carryout planning tasks and duties.
 - *Inclusion* is defined as meaningful involvement of members with an active voice in decision making.
 - *Representation* is defined as the act of serving as an official member who reflects the perspective of a specific community.
5. An inclusive community planning process includes representatives of various races and ethnicities, genders, sexual orientations, ages, and other characteristics, such as educational backgrounds, professions, and levels of expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process, and candidate selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiological profile and the community services assessment.
9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.

The set of prevention interventions and activities for prioritized target populations should have the potential to prevent the greatest number of new infections.

ORIGINS AND PURPOSE OF HIV CARE PLANNING

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. The CARE Act was reauthorized in May 1996 and again in October 2000. In 2006, it was reauthorized and entitled the Ryan White HIV/AIDS Treatment Modernization Act. The Act is administered by the HRSA.

Ryan White services are intended to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life for those affected by the epidemic. The Ryan White Program works toward these goals by

providing primary medical care and support services; healthcare provider training; and technical assistance to help programs address implementation and emerging HIV care issues.

Part B (formerly Title II) of the Act provides funds to States and territories for primary health care, including HIV treatments through the AIDS Drug Assistance Program (ADAP) and support services that enhance access to care to PLWHA and their families. It requires states to engage in a planning process that will secure broad input in the development and implementation of the comprehensive plan for delivery of care services.

HRSA requires IDPH to coordinate and develop a Statewide Coordinated Statement of Need (SCSN) and a corresponding strategic plan for the organization and delivery of HIV care and support services. IDPH is expected to provide the following planning-related information in describing its use of Part B funding:

1. The purposes for which the state intends to use the funds, including the services and activities to be provided, and an explanation of how the state would maximize the quality of health and support services available to all PLWHA.
2. A description of how funded services will be coordinated with related services and health care delivery systems for individuals with HIV disease.
3. A description of how the allocation and use of resources are consistent with the SCSN, which was developed in partnership with those who provide care services to PLWHA.
4. Results of a needs assessment that determines the size and demographics of the population of individuals with HIV disease.
5. A plan, developed in consultation with PLWHA and public health and community-based providers that will ensure the delivery of services to meet identified needs.

Comprehensive Planning Process: Care

Building upon epidemiological data and other needs assessment information, the comprehensive planning process examines HIV care needs for the State and assesses the resources available to meet those needs and to overcome barriers to service provision. The comprehensive plan sets long-term goals while addressing the vision and values that guide Iowa's development of a system of care.

Part A: Introduction

Chapter 2

Overview of the Iowa HIV Community Planning Group



Overview of the Iowa HIV Community Planning Group

The *Iowa Comprehensive HIV Plan* requires broad-based community participation for HIV prevention and care planning. The Iowa Community Planning Group (CPG) uses multiple methods and distinct planning processes to ensure that:

- Members are representative of the diverse populations most at risk for, infected with, and affected by HIV;
- Professional expertise and representation from key governmental and non-governmental agencies occurs; and
- The process encourages inclusion and parity among community planning members.

This chapter gives a description of the following community planning aspects:

- **The history and structure of the Iowa Community Planning Group**
- **Participants in the planning process**
- **Education for CPG participants**

History and Structure of the Iowa Community Planning Group

The Iowa Department of Public Health (IDPH) HIV/AIDS Program initiated an HIV prevention community planning process in 1994. In 2001, the HIV Community Planning Group (CPG) integrated care planning into the process. In 2005, the CPG expanded its statewide care planning component to increase consistency in delivery of services across the state. The Iowa planning process embraces participatory community planning as an essential component for building effective statewide HIV prevention and care programs.

Leadership The IDPH selects an employee, or a designated representative, as one co-chair, and the CPG selects a community co-chair. The co-chairs share responsibility for guiding the CPG in accomplishing its mission and goals.

Committees To accomplish the tasks identified by the CPG, smaller working groups, or committees, were developed to examine issues and develop recommendations more productively. The CPG currently has eight committees: (1) the membership, orientation and bylaws committee (MOB), (2) the epidemiological profile and information committee (EPIC), (3) the needs assessment/community resources committee (NARC), (4) the access and care committee (AC), (5) the strategies for prevention interventions and community endeavors committee (SPICE), (6) the quality assurance/case management committee (QM/CMS), (7) the public relations (PR) committee, and (8) the ad-hoc prioritization committee. Committee members elect a chair for each committee. The committee descriptions and tasks are listed below.

Committee Descriptions

Membership/Orientation/Bylaws Committee (MOB)

- Review membership composition
- Release “Call for Applications”
- Select CPG Members
- Provide orientation to new members
- Review and update bylaws and job descriptions as necessary
- Assist with overview of the planning process
- Develop and coordinate a CPG mentoring program
- Develop a work plan/timeline for the CPG
- Review, identify and make recommendations for technical assistance (TA) needs for the CPG, HIV/AIDS/Hepatitis Program, local government agencies, and community-based providers in the area of community planning, implementation of programs, and evaluation
- Assist with evaluation of the community planning process

Epidemiological Profile and Information Committee (EPIC)

- Review the epidemiological information/data presented by the HIV/AIDS/Hepatitis and STD Program surveillance staff
- Contribute to the collection and presentation of epidemiological data
- Review and comment on the epidemiology section of the plan

Needs Assessment/Community Resources Committee (NARC)

- Review behavioral studies; Knowledge, Attitude, Behavior, and Belief (KABB) studies; and other information about the needs of the groups at risk
- Develop an unprioritized list of target populations
- Review needs assessment information and identifies gaps in knowledge/services
- Select populations for focus groups
- Assist and comment on the needs assessment section of the plan.
- Conduct a community services assessment, in collaboration with the Access and Care Committee.
- Maintain an inventory of resources and needs assessment studies

Access and Care Committee (AC)

- Assist in the development, coordination, distribution, and analysis of a Consumer Needs Assessment in collaboration with the NARC committee
- Contribute to the development of the Statewide Coordinated Statement of Need
- Contribute to the development of the Strategic Care Plan section of the plan
- Collaborate with NARC on the community services assessment

Strategies for Prevention Interventions and Community Endeavors Committee (SPICE)

- Develop an unprioritized list of appropriate science-based prevention activities/interventions: a set of prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations

- Provide oversight for and contribute to a literature review of strategies/ interventions
- Review information about intervention effectiveness
- Assist with intervention assessment
- Contribute to and review the intervention prioritization section of the plan

Quality Assurance/Case Management Committee (QA/CMS)

- Develop and co-facilitate Ryan White 101 training for Ryan White Part B providers
- Develop a Resource Manual for Part B providers
- Assist IDPH in the development of a Quality Assurance Plan that includes performance measures and baseline data
- Develop and evaluate case management standards
- Develop and evaluate an acuity scale
- Develop standardized case management forms
- Facilitate unit-cost analysis for case management services

Public Relations Committee (PR)

- Research, review, and recommend actions and positions for the CPG on various issues
- Assist IDPH with the development of a process for disseminating a plan or a summary of the plan among the affected communities and the general public

Prioritization (Ad hoc)

- Guide the CPG through the prioritization of populations for HIV prevention, including assisting with the development of population-level criteria and weighting factors

Meetings The CPG meets in person for a full day five to six times a year. At each of these meetings, the community-at-large is invited to provide comments during a pre-scheduled time in the afternoon. The co-chairs of the CPG and the chairs of each committee meet via conference call on the interim months. The committees meet at regularly scheduled full meetings, at additional convenient times and places for members, and through conference calls as needed. An overview of current committees' activities is provided to CPG membership at full meetings. Through this structure, which encourages the sharing of information from all levels of CPG participation, the CPG ensures that each member has an opportunity for valuable input.

Participants in the Planning Process

Applications for membership to the CPG are solicited through an open process and applicants are selected using criteria established by the CPG and the IDPH. The nomination and selection of new community planning group members by the CPG MOB

Committee occurs in a timely manner to avoid vacant positions or disruptions in planning. In addition, the recruitment process for membership in the HIV community planning process is proactive to ensure that socio-economically marginalized groups and groups that are under-served by existing HIV programs are represented.

Applications for membership are distributed to all HIV prevention and care providers through mailings and at meetings. During the annual HIV/AIDS conference, sponsored by the IDPH, the Iowa Department of Education, and the CPG, applications are widely distributed to reach many more potential CPG members. The CPG also actively recruits new members who represent the population characteristics of the current epidemic in Iowa and the diversity of perspectives of those affected by HIV. Finally, a wide variety of areas of expertise should be available to the CPG, through its membership, IDPH staff, and consultants involved in the planning process.

Members are selected using the following criteria:

- The applicant reflects the characteristics of the current and projected epidemic (as documented by the epidemiological profile) in terms of age, gender/gender identity, race/ ethnicity, sexual orientation, socioeconomic status, geographic distribution (urban and rural residence), and risk for HIV infection.
- The applicant represents one or more of the following constituencies or areas of expertise:
 - a. state and local health departments, including HIV prevention, Ryan White, and STD programs;
 - b. state and local education agencies;
 - c. other relevant government agencies (e.g., substance abuse, mental health, corrections);
 - d. epidemiology;
 - e. behavioral and social sciences;
 - f. program evaluation;
 - g. health planning;
 - h. key non-governmental and governmental organizations providing services to persons with or at risk of HIV infection (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, other social services); and
 - i. other organizations that have key roles in the lives of those affected by HIV (e.g., representatives of business, labor, and faith communities).
- The applicant is able to fulfill commitments to the CPG's work.
- The applicant is able to relay pertinent information between the CPG and his/her constituency in the community.

The number of CPG members ranges from 30 to 45 persons. The HIV/AIDS/Hepatitis Program provides technical support as needed. In addition, the IDPH Assistant State Epidemiologist, IDPH Medical Director, and Kent Sandstrom, Associate Professor of Sociology, Department of Sociology at the University of Northern Iowa serve in advisory capacities to the CPG. A member of the National Behavioral Social Science Volunteer Program is a voting member of the CPG.

Inclusion

To ensure that all interested parties beyond the community planning membership are encouraged to participate, the CPG routinely and informally shares and collects information from the constituencies that they represent. Members are reimbursed for travel expenses incurred when attending meetings. If a member knows that she/he is or will have a difficult time attending meetings because of health or other extreme reasons, the member may resign for a period of time not to exceed six months. If the issues have been resolved within the six-month leave period, the member may reapply for membership.

The CPG seeks additional avenues for obtaining input on community HIV prevention and care needs and priorities by conducting focus groups, key informant interviews, consumer surveys, and needs assessments. From 1999 – 2004, Young Adult Roundtables (YARTs) functioned to secure input from high-risk youth. Selected sites for YARTs were Davenport, Des Moines, Mason City, and Sioux City. A summary of the YART discussions can be found in Chapter 4.

Parity

To achieve parity, members are provided with opportunities for orientation and skills building to help them participate actively in the planning process and to have equal voice in voting and other decision-making activities.

IOWA HIV COMMUNITY PLANNING GROUP COMPOSITION

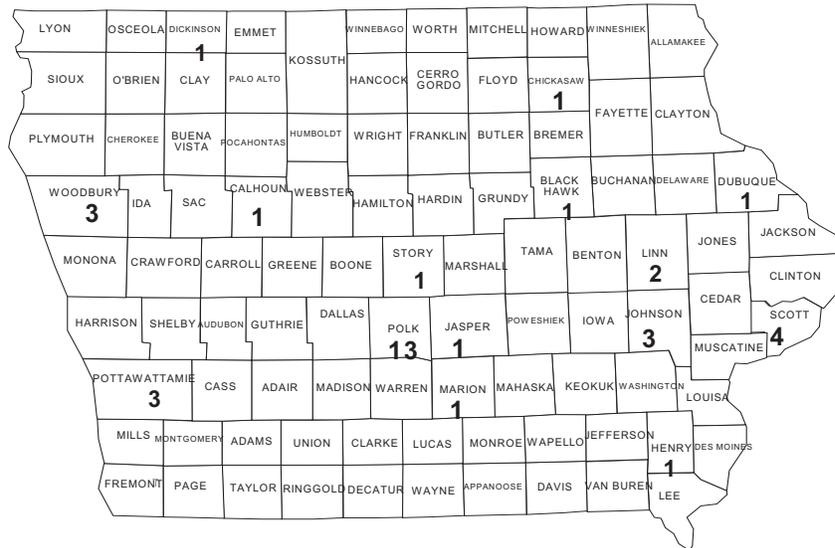
Date: August 2006

Total number of voting members: 37

Gender	
Males	15
Females	21
Transgender	1

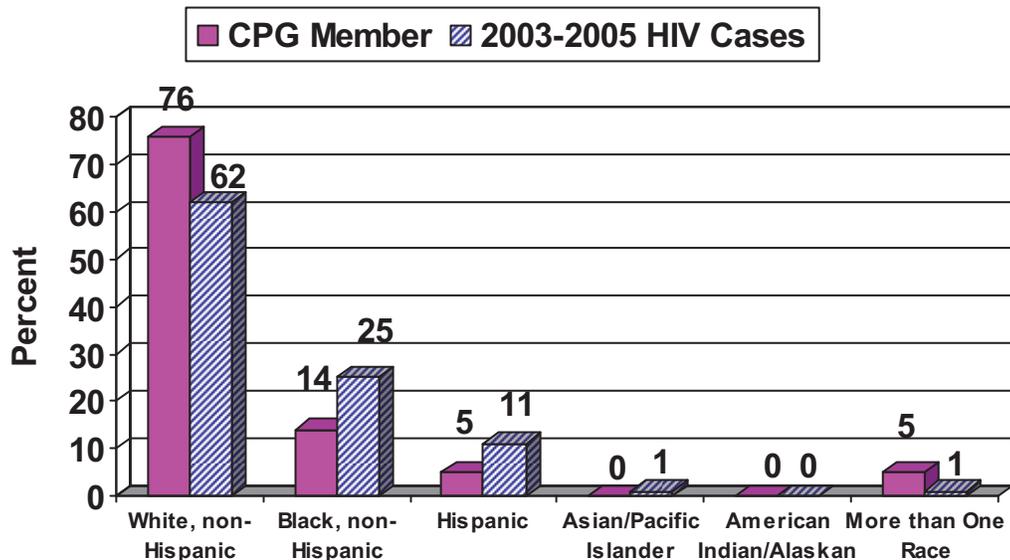
Age	
<19	0
20-24	0
25-29	4
30-49	23
50+	10

Geographic Distribution of CPG Membership



5 members represent statewide organizations

Racial/Ethnic Representation of CPG Compared to Epidemic



Connection of Members to HIV/AIDS

HIV Risk Categories	
Men Who Have Sex With Men (MSM)	12
MSM and Injection Drug User (IDU)	0
IDU	2
Heterosexual	10
Mother with or at risk for HIV infection	0
General Public	13
Unknown	0

Members Living with HIV	
Yes	12
No	25

Members Not Living with HIV but Affected	
Yes	12
No	25

Agency Representation

Primary Agency/Other Representation	
Faith Community	0
Minority Board CBO	1
Non-minority Board CBO	5
Other Non-profit	3
State Health Department	5
Local Health Department	4
Other Government	3
Academic Institution	2
Research Center	0
Individual (person)	12
Other	2
Unknown	0

Secondary Agency/Other Representation	
Faith Community	0
Minority Board CBO	1
Non-minority Board CBO	3
Other Non-profit	1
State Health Department	0
Local Health Department	1
Other Government	0
Academic Institution	1
Research Center	0
Individual (person)	1
Other	5
Unknown	0

Expertise of CPG Members

Primary Expertise of CPG Members	
Epidemiologist	1
Behavioral or Social Scientist	3
Evaluation Researcher	0
Intervention Specialist	6
Health Planner	4
Community Representative	16
Other	7
Unknown	0

Secondary Expertise of CPG Members	
Epidemiologist	1
Behavioral or Social Scientist	2
Evaluation Researcher	1
Intervention Specialist	7
Health Planner	3
Community Representative	3
Other	3
Unknown	0

Education for CPG members

New members receive a thorough orientation from the MOB Committee. This committee also is responsible for the implementation of the CPG Mentor Program, which provides ongoing support to new members.

The orientation includes descriptions and discussions of:

- The history of the CPG and its decisions to date;
- The three community planning goals and the ten guiding principles;
- HIV prevention priorities and interventions;
- HIV care priorities and expectations;
- Iowa's Comprehensive HIV Plan;
- The roles and responsibilities of CPG members;
- How community planning fits into the context of IDPH comprehensive HIV prevention and care programs; and
- Specific policies, procedures, and ground rules.

CPG member orientation has been further enhanced by the following developments:

- The MOB Committee developed a PowerPoint presentation to facilitate discussion with new members during orientation. Three months after a member completes orientation, they are asked to complete an orientation evaluation and changes are made accordingly;
- The co-chairs routinely review CPG norms/ground rules at the CPG meetings; and
- A mentor is assigned to new members who would like further guidance and orientation to the community planning process.

A mentor is an established CPG member who works closely with a new member, giving guidance on the obligations and responsibilities of a CPG member. The mentor is assigned to the new member when he or she is seated. The role of the mentor includes working closely with the new member by calling and/or sitting with the new member for three to six months and being available for the first year as needed.