

**California HIV/AIDS Planning Group  
Design Summit Meeting  
Los Angeles, California  
March 18 -19, 2009**

The California HIV/AIDS Planning Group (CHPG) met in Los Angeles to take a broad look at community planning. The purpose of the meeting was to discuss the function, future, and structure of community input/engagement, to ensure that various stakeholders and the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) best work together to plan over the short- and long-term for appropriate HIV prevention and care services in California.

A Design Team consisting of four community members and four OA staff has been charged by the larger group to conduct research into best practices around the United States and to utilize the results of the first summit to arrive at one-to-three prototype designs that the larger group can discuss and decide upon at a second summit in June 2009. Community Design Team members are: Monique Collins, Ricky Rosales, Ellen Swedberg, and Steven Tierney. OA Design Team members are: Jeff Byers, Brian Lew, Alessandra Ross, and Peg Taylor.

These notes capture the main points discussed and recorded on chart pads during the meeting. We are indebted to Susan Forrest for typing up the many pages of chart pad notes that were generated by the Summit.

**CHPG members in attendance:**

Bart Aoki, Jeff Bailey, Maria Baldovinos, Fredy Ceja, Terry Cunningham, Cynthia Davis, Susan Forrest, Tari Gilbert, Nyrza Gonzales, Toni Harrison, Anthony Huynh, Precious Jackson, Michael Johnson, Robert Lewis, Debra Lyn McCarthy, John Melichar, Fernando Ocana, Mario Perez, Christopher Ried, MD, Ricki Rosales, Paul Sanchez, Fernando Sanudo, Rosana Scolari, Terry Smith, Don Soto, Ellen Swedberg, Steven Tierney, and Jason Tokumoto, M.D.

**Members not in attendance:**

Rachel Anderson, Cesar Cadabes, Michael Cunningham, Sharon Grayson, Dorothy Kleffner, Marge Kleinsmith, Greg Mehlhaff, Adrienne Rogers, Joy Rucker, and Sharla Smith

**OA staff in attendance:**

Brian Lew, Peg Taylor, Jeff Byers, Alessandra Ross, Mary Anne Selvage, Joseph Arellano, Kama Brockmann, Carol Crump, Valorie Eckert, Michael Foster, Richard Iniguez, Amy Kile-Puente, Clarissa Poole-Sims, Michelle Roland, Carol Russell, and Liz Voelkert.

**Facilitators:**

Patrick McNamarra and Duncan Teague

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**DAY 1**  
**9 a.m.**

**Welcome/Call to Order**  
Introductions  
Moment of Silence  
Goals and Expectations

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The basic intent of the community planning process for 2009 is to design the HIV/AIDS community engagement process and structure by November 2009. OA has three primary needs that can be addressed through community input/engagement:

- Planning;
- Advising on OA-generated issues; and
- Advising on community-generated issues.

All of these should include both prevention and care issues.

Planned timeline for the redesign process:

- March: envision and prioritize design elements;
- June: recommend a planning and advising process; and
- November: ratify the new process.

### **Expectations/Hopes for the Summit**

Participants wanted:

- Open, honest, focused dialogue, and collaborative process;
- Clarity of purpose and role, clarity, ideas, re-invigorate the planning group;
- Hear new ideas, new approaches and suggest a way to move forward;
- See how all pieces fit together, consolidate efforts of all organizational elements;
- Greater clarity/ direction/ expectations from OA so our work can impact a large number of people across the state – a new process that will make a difference;
- Build a solid framework, that results in a good plan;
- Hopeful that we will be able to design something effective with a clear mission and process;
- Be less confused and less anxious so I can articulate what is needed here; and
- Create the best HIV/AIDS planning process in the United States.

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**9:20 a.m.**

### **Agenda Review, Key Questions**

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Setting the Context: Planning and Advising.

A new way of working on planning and advising:

- Common process: Community and OA work together toward common goal of planning and advising;
  - Clear direction: ask for clarity if things are fuzzy, name unspoken assumptions;
  - Iterative process: OA engaged in the process and provides ongoing feedback each step of the way; and
  - Useful: keep asking... is this useful, effective, proactive? Will this help us
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stay ahead of the epidemic?

Three components of planning and advising need to be considered:

- 1) Funder-required planning - CHPG must play a role (with OA) in this for both the Centers for Diseases Control and Prevention (CDC) and Health Resources and Services Administration, so this must be a focus of the discussion;
- 2) Advising on OA-generated issues; and
- 3) Advising on community-generated issues.

Ideally, the discussion will address all three areas, and address the relative roles of various groups involved in planning and advising across the state.

### **Planning and advising efforts need to be integrated with OA planning.**

Tasks:

#### Advising

- Short-term issues impacting those with HIV/AIDS;
- Input on local impact and emerging trends;
- View “from the street level;”
- Top to bottom/ bottom to top;
- Talking freely and communicating about the “real world;” and
- Talking about a specific topic or issues – free dialogue.

#### Planning

- Drafting of funding documents;
- Bringing “experts” to the table;
- Learning from collective knowledge; and
- Planning based upon need.

- ★ CDC will provide a two-year bridge grant prior to a new five-year grant cycle. **This means that CDC does not require the Prevention Plan, which OA is required to seek community input on, to be completed until 2012.**

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### **9:45 a.m. Expanding the Data**

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Prior to the meeting, the facilitators and members of the Design Team conducted 60 interviews with individuals around the state involved in HIV/AIDS community planning either at the state or local level. To launch the day, meeting participants interviewed each other in order to expand the data already collected by the Design Team. Questions included:

1. As you know, in order to "stay ahead of the epidemic," community input is a useful way to engage people with HIV/AIDS, those at risk, and agencies that
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work with them to learn how to better reach and serve those who are impacted. Community planning in some form is also required by funders for HIV prevention and care.

Please share an example where community planning or advising made a difference as an important component in staying ahead of the epidemic.

2. What do you value most about what you bring to the planning group?
3. What key things are getting in the way of us working together effectively to stay ahead of the epidemic?
4. If you could change one thing about how HIV prevention and care planning is done, what would it be?

Key themes from this activity included:

**Our role: representation**

- Utilize talent here in more meaningful way (tell members which strengths brought you here);
- Leave own agenda at home, focus on your role; and
- To put time into an issue does not mean some other issue is less important.

**Base decisions on data**

- Look at data more often and make decisions based on that;
- It starts with OA presenting data that gives us a picture; and
- Need data and expertise... that expertise needs to be respected.

**Better communication**

- Better COMMUNICATION between OA and planning body;
- Missing ⇒ a starting point to help define roles;
- Maybe the big larger group is not the way to go – maybe the roles are “smaller” “focused;” and
- Key point: focus on expertise.

**Clarity of task and roles**

- Clear understanding of what is needed (tasks) and clear steps (roles);
- Lack of clarity on roles and what members are here to do; and
- OA staff members may be unclear about their roles on the body.

**Focus, clear goals, leadership**

- Focus effects both community and state;

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- Clear goals for this group, for ad hoc groups; and
  - Clear, strong facilitation and leadership.

#### **Dialogue and engagement**

- Create opportunities for meaningful dialogue and exchange;
- Spirit of dialogue between OA and community;
- System of collaborative dialogue: state, OA, community;
- Provide a structure to present a community view; and
- Allow individuals to really participate.

#### **Include local level**

- Include local level in developing goals and strategies;
- Direct tie to LOCAL PLANNING;
- GRASSROOTS involvement; and
- Clear recruitment strategies and membership criteria.

#### **Who do we serve?**

- CHPG needs to know: who are CHPG's customer(s)?
- CHPG serves people who are at risk of acquiring HIV, HIV-positive individuals, and those living with AIDS. Prevention and care are the focus.

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### **10:45 a.m. Strengths, Challenges, Aspirations, and Results**

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This discussion of interview data was followed by a presentation of data from the 60 pre-summit interviews – highlighting when community engagement works well, opportunities for improvement, our common goal, hopes, and thing we must have in the new process and structure.

#### ***See attached PowerPoint***

After the presentation, participants commented:

- Three key issues seem to repeat: clarity, communication, and trust; and
  - How can we take a broader view?
    - Open it up and talk about more global things;
    - Bring perspectives new to us;
    - We are not sure this is sufficiently “out of the box;”
    - Does there need to be a body?; and
    - What have we not heard?
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12 p.m.

**LUNCH**

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1 p.m.

**Vision of Community Engagement**

Afternoon Goal: Draw out vision of a community engagement process and structure that is effective and useful.

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In the afternoon, participants reflected on the question: What can excellent community engagement achieve? Answers were grouped into eight categories to be considered in the prototypes of the future planning process and structure.

**What can excellent community engagement achieve?**

**1. Achieve results, meet our goal.**

- a. Results in informed policy and protocols: on-target solutions;
- b. Helps maintain quality of service, usable ideas, implementation of strategies;
- c. Building/retooling a sustainable service delivery model;
- d. Achieves better outcomes: a comprehensive HIV prevention and care response; and
- e. More effective services, targeting those most effected, prioritizing needs and fulfilling them one step at a time.

**2. Informed and responsive decision making**

- a. In order for CHPG and OA to make informed decisions, information must always flow (continuous, accurate, timely);
- b. Promote a shared, collaborative and responsive purpose;
- c. Resulting in the best possible, truly informed, decision making and prioritization at the state, local, and community-based organization (CBO) level;
- d. Diverse, independent, knowledgeable, and impassioned criticism and advocacy for the state's HIV/AIDS policies and programs;
- e. Know what the constituencies' needs are; and
- f. Cross-issue learning and support.

**3. Prioritizing needs and understanding/understandable data**

- a. Excellent community engagement enables creation of reality-based policy to address actual needs;
- b. Reality-based programming and funding allocation;
- c. Agile resource allocation, maximizing good for the greatest number; and
- d. Keeping what works and discarding what does not.

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#### **4. Communication and trust:**

- a. Bi-directional communication between community and government – a working and true partnership with a common objective: to address the disease:
  - i. Informed dialogue, appropriate, full input – a collective process where all voices are heard, trust and respect among all constituencies;
  - ii. Timely and appropriate creation of dialogue on recommendations based on data, experience and focused passion;
  - iii. Two-way info sharing to identify trends and late-breaking issues and give the OA the community's point of view;
  - iv. Ownership of the plan: a sense that the epidemic is being addressed;
  - v. Balance: trust, compromise, honesty, highly-responsive to needs.

#### **5. Thinking beyond government organizations**

- a. Work as partners to leverage all available resources and share information and strategies;
- b. To create programs together that achieve results;
- c. Include non-clinical perspective on prevention strategies and care treatments;
- d. Our work will also create policy and program change outside OA.

#### **6. Cross-jurisdictional planning body**

- a. Produce positive, effective results and interactions both locally and statewide that benefit all infected/affected communities; and
- b. Get CHPG folks to local community to be part of existing social activist groups (peer-to-peer input).

#### **7. Advocate/influence at a national level**

- a. Achieve the ability to project future trends and ways to proactively resolve epidemic issues statewide;
- b. Enable state and local partners to advocate with maximum effectiveness at the federal level; and
- c. Achieve national influence on policies and funding for AIDS programs based on our ability to identify with most geographical settings (rural, urban, and in between).

#### **8. Facilitate change at all levels**

- a. Influence on a national, state, and local level;
- b. De-stigmatize health issues on an individual/cultural level;

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- c. Enhance community members' pride: being part of the solution;
  - d. Re-energize local activism and support of local communities; and
  - e. More time spent on bigger issues than micro issues.
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**2:15 p.m.      Rapid Prototyping**

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The group created "rapid prototypes" to get a quick look at the community engagement process of the future. From these prototypes, several ideas came forth that could be used in design.

**Themes from Prototypes**

- A clear overall goal: to eradicate the disease;
  - Continuous process, flexible, potential for fast response;
    - Multi-directional, interdisciplinary, interdependent.
    - Timely, accurate data.
    - Ensure essential elements for success.
  - Communication and collaboration to move the process forward and provide cross-pollination;
  - Consistent, smaller, ad hoc task forces and meetings with a unifying, statewide connection;
    - Goal setting on local and issue levels, set priorities, recommend new ways of looking at things, include emerging/special constituencies.
    - Local groups have a role in a local input process with broad-based community representation – increased access to community participation.
    - Face-to-face meetings of smaller task forces.
    - On-going community forum to gather community input
  - Geographic, broad-based representation should help with goal setting;
    - Inclusive and participatory, yet efficient and flexible process.
    - Get the community voice with focus groups and technology (Webcam, Internet).
  - Include a resource pool of individuals, experts, and policy makers;
    - The right people at the table.
    - Acknowledge the restrictions of government while nurturing advocacy.
    - Together we can overcome roadblocks and eradicate the disease
  - Funding;
    - Is an enlightened process.
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- Acknowledges government restrictions.
  - New growth in funding plus leveraged resources.
  - Technology to assist in making adjustments (reposition) and to ensure success in meeting the overall goal;
    - Web-based meetings
  - The right people with the right information at the right time results in great decisions that make a huge impact on many levels;
    - Impact: populations, regions, national, state.
    - Service providing, policy making, research.
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**4:30 p.m.      Initial Design Elements**

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The group finished the day by brainstorming a list of design elements to use in the in-depth discussions planned for Day Two (See notes for Day Two).

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**DAY 2**  
**9 a.m.**

**Welcome**

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The goal of the second day was to focus more narrowly on questions of what community input and engagement might look like in the future. In the morning, the group participated in discussions to articulate specific components of what needed to be included in the design, in such categories as membership, clarity of roles, and use of technology. In the afternoon, participants worked to articulate the design components in a more concrete way and to prioritize what is most important to the group.

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**9:15 a.m.**

**Design Element Review**

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A consolidated list of design elements was used to structure discussion on Day Two.

**Consolidated Design Elements**

1. Clear mission and measurable goals.
2. Planning and advising structure.
  - a. How to keep flexible.
  - b. Advising.
  - c. Strong work plan with timeline.
  - d. Accountability.
  - e. Keep members involved between meetings.
  - f. Nimble, flexible process.
3. Clarity of roles.
4. Membership.
  - a. What are expectations?
  - b. What are outputs?
  - c. Review application.
  - d. Keeping engaged between meetings.
5. Accountability and responsibility in many directions, especially to the people we serve.
6. Communication and building trust.
7. Data/technologies.
  - a. Using new technologies and innovative ways of working.
  - b. Incorporate data most effectively.

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8. Pros and cons of having a statewide body.

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**9:30 a.m. Public Comment**

There was no public comment.

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**9:45 a.m. World Café and Small-Group Work**

Morning and afternoon notes combined.

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On the second day, the group held more focused discussions on the above design elements in order to arrive at a shared view of how each element should be crafted in the new planning and advising process and structure. The larger group broke into several smaller groups in order to consider these elements.

In some discussions, such as the one addressing the element of “structure,” initial discussions were varied, and the Design Team may need to consider several views as they create a prototype structure and process for the group to review in June 2009. In other discussions, such as the one on “membership,” there was agreement within the small group which originally considered the item, however, members in the larger group shared opposing views when these ideas were presented to the larger group. In yet other groups, such as “clear mission,” there was a sense of consensus throughout discussions. The Design Team will consider all views, as well as feedback it receives between summits in order to create prototype(s) for the larger body to consider in June 2009.

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**1. Clear Mission**

- Restate our vision in partnership with OA: HIV-free California.  
Stressing the word *partnership*.  
Comprehensive Care and Prevention plan.  
Is OA effectively addressing those plans?
- Redefine the community: who are the voices?
  - Groups; individuals from where?
  - Should there be separate or joint care and prevention plans?
  - How is “joint” defined?
- OA needs a dedicated staff person to support planning process.
- **Vision:** In partnership with OA we work to create an HIV-free California and a state that provides effective and compassionate care to all those living with HIV/AIDS.
- **Mission of Planning Group is to:**
  - Play an active role in the development of a comprehensive AIDS care plan, Statewide Coordinated Statement of Need (SCSN), and a comprehensive HIV prevention plan.

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- On an annual basis, engage in activities designed to determine that the work of OA is effective in addressing the plan.
  - Provide periodic advice on emerging issues generated by OA and the community.

## **2. Planning and Advising Structure** (initial discussion)

- Regional Model (south, central, north);
- Committees/Task Forces/Small Groups do in-depth work;
- Include operational standards; priorities; advocacy; assessment;
- Look at Education ⇒ Testing ⇒ Diagnosis;
- Large Group Summit; epidemiologic profiles; needs assessment; gap analysis (treatment gaps);
- Service priorities and prevention interventions ⇒ greater communication in regions;
- Three-to-five-year plans; and
- Get together once a year; letter of concurrence; and plan development.

### **Feedback from larger group:**

This recommendation is very technical in its duties.

What are we really looking for? Is it technical expertise? That's OA's job.

OA needs to make sure plan works.

People need to say "it works and this is why..."

There needs to be a middle ground (where the planning body does some more technical work).

Need high-functioning, educated, intelligent people and they can engage in planning and advising.

Membership/communication needs to be considered.

Concerted efforts to get traditionally under-represented folks at the table.

### **Structure** (In depth discussion)

Considered models:

#### **Model 1:**

This model begins with a description of the current continuum of services for people with or at risk for HIV/AIDS. The model assumes this continuum to flow as follows:

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- ❖ Educational services;
  - ❖ HIV counseling and testing services;
  - ❖ Diagnosis;
  - ❖ Clinical and support services; and
  - ❖ Independence.

The model:

1. Focused on developing care/prevention plan (every three to five years).

a. Data summit – current state of the epidemic.

- i. Two/three days.
- ii. Consider (data), distill, direct – to inform the plan.
- iii. Data for a plan.
- iv. Research: use epidemiology data.

b. Needs assessment and gaps analysis.

c. Input – gather from larger community.

- i. Northern
- ii. Southern
- iii. Central
- iv. Rural
- v. Urban
- vi. Local Implementation Groups (LIGs)
- vii. Ryan White Planning Councils

d. Develop priorities that target specific populations/geography, etc.

e. Identify services and interventions to meet the needs.

At this point the input/planning process ends for the current cycle of planning (three to five years)

f. Procurement – state secures the services/interventions.

g. Concurrence and State of the Epidemic – annually - group meets to concur that the state has complied with the HIV/AIDS care and prevention plan. The State provides a current state of the epidemic update. Opportunity for the group to address previously unknown or unforeseen financial/programmatic/emergency issues.

### **Structure: Feedback on recommendations**

May be emerging areas of focus

Do an addendum to the plan to include and shift these resources

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Planning councils throughout CA should be used to populate CHPG  
Significant consumer input comes from local jurisdictions

**Model 2:**

Input structure, include:

- Geographical groups - northern, central, southern.
- Subgroups - rural, urban.
- Membership to the regional group would come from the local Transitional Grant Area/Eligible Metropolitan Area (TGA/EMA) Ryan White Planning Councils for Care Treatment and Support services and Local Implementation Groups for Education and Prevention Services.
- Members from the regional groups and subgroups would be nominated to a statewide body for developing the 3-5 year Comprehensive HIV Care and Prevention Plan for California.
- Members would therefore be directly tied to their local and regional groups and be able to provide feedback locally and to the statewide body regarding local issues.

**Model 3:**

Structural components of design:

Operations: Charged with the obvious basics but also recruitment, interviewing, trainings, assessment of the administrative mechanism (contracting authority) and special projects which frequently turn into tasks passed on to the other subject matter committees. It also supports the Consumer Caucus for the HIV+ members to get together and share needs, insight and concerns.

Standards of Care: Charged with setting minimum standards for each service category funded under Ryan White and service categories funded by the County under net county cost (NCC). It is a great resource to explore current best practices and formulate strategy with providers to adopt the highest standards within our resource pool.

Public Policy: Charged with agenda setting for county measures, state legislation and federal legislation to watch, support and/or oppose. (This has constraints based on the County Dept of Governmental Relations). We do make recommendations to each branch of government on issues and assist other groups to coordinate efforts along mutual goals.

Priorities and Planning: Charged with establishing operating values and paradigms for each year, (the lens we view allocations, i.e. utilitarian, compassion, equal access, etc.) Once established, we then prioritize the service categories in our continuum of care county wide. Some things are

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funded through RW, NCC or other state/federal money. However, for this stage, we simply attach a priority: What is the most important services/benefit consumers need. Once the priorities are set, we then go back and allocate percentages of RW funds according to funding availability, other streams of funding, etc. We've found this way maximizes our RW funds and could be similarly adopted to address those areas the State must address first as it is the payor of last resort on a service category.

**Issues expressed as concerns regardless of model:**

- Health disparities;
- Co-factors;
- Homophobia; and
- Other driving factors of infection.

Need to assess Rapid Response.

State should be able to get advice... outside of this body.

CHPG ⇒ development and execution of a plan.

**3. Clarity of Roles** (initial discussion).

Clarity of Roles: both planning and advising are roles for the body.

Issues the OA needs:

Planning prevention and care; long-term effort.

Tasks Advising

- Short-term issues;
- Input from local community (a view from the street); and
- Talk and communication about the real world.

Topics that impact a specific community

**Clarity of Roles** (in depth discussion)

**OA Charge to Community Planning Process**

Actively involved in:

WRITING the plan

- Active role in writing comprehensive care plan and active role in writing comprehensive prevention plan.

MEETING the plan

Concur on annual basis that OA effort effectively addresses the plans

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## Function ⇔ Process

What is the ROLE of community planning in the state?

Group asked Design Team to get best practice data from states like:

- Data – New Mexico, Nevada, and New York who have innovative community engagement processes.

## Clarity of Roles (in depth discussion)

OA ⇔ Statewide Group(s) / Members ⇔ People

### Group Role

- Org chart of groups;
- Define groups relationships/tasks;
- Work plan/timeline; and
- Method to get expert input.

### Member Role

- Job descriptions.
- Accountability process.
  - Change members if needed.
  - Timeline/work plan.

### Overall

- Need from DT how SG fits into universe.
- Added to group roles – ability to create ad hoc groups (understandable process).
- Need multifaceted, multidirectional communication methods.
- Process will be able to address emerging issues.

## 4. Membership (initial discussion)

Tell members why they were selected so they can participate with that in mind.

Have job descriptions with expertise.

Accountable to roles/mechanism when not fulfilling roles.

Satellite groups for populations.

How to bridge OA ⇔ satellite groups.

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- We need to be the conduit and get peoples' thoughts.

Need to include training, mentoring and intervention

Transparency

- Bios and contact info available of representatives
- Role in the planning process (e.g. on an advisory committee)

### **Feedback from initial discussion**

Include networking structure from 'plan 2' (membership / communication)

Concerted efforts to set traditional under-represented folks at the table

### **Membership** (detailed discussion)

Membership should consist of

- One-third consumers;
- One-third providers;
- One-third OA.
- Fifty percent suggested HIV-positive people.
- Explain to members why they were chosen.
  - Detailed job description
- Accountability

### **Membership – Issues of Concern**

- New funding.
- Emerging trends.
- One day meeting(s).
- Expand data – include cofactors.
- Rapid response possibilities?
- Include possible addendums and ad-hoc groups.
- Consumer caucus.
  - Alternates.
  - Still held accountable.
- Financial barriers to membership

### **Membership: Recommendations**

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- Ongoing membership review.
    - How are we doing?
  - Mandatory mentor – one year newbies.
  - Recruitment seminar.
    - Local planning councils.
  - Leadership seminar.
    - Teaching consumers how to engage in process.
  - Members at large (two).
    - No voting rights.
    - Only consumers.
    - Scholarship-driven.

#### **5. Accountability** (initial discussion).

Being accountable to the:

- People we serve.
- OA.

Advisory Board

- To follow the recommendations and money that passes through.
- Feedback back to the community and OA.

Agencies serving highly impacted areas

- Accountability for specific contracts

#### **Recommendations: Accountability**

Broaden the work so there are different perspectives.

Do not put everything on OA's shoulders.

Planning Group members also accountable.

Ensuring accountability for specific contracts.

#### **Accountability** (no in depth discussion)

#### **6. Communication and Building Trust** (initial discussion).

Trust would come from better communication.

Clear timelines; multidirectional; complete; accurate; consistent with community planning.

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### **Recommendations: Dedicated OA Planning Unit**

Dedicated OA Planning Unit.

Communication among planning groups within the council.

Need communication with those groups and OA.

Have a common language.

Have training on what our role is in legislation and what really happens (your role, our role).

### **Recommendations: Communications**

Quarterly conference calls for updates only - what's happening with every branch.

Representatives from every group for purpose of update.

Dedicated staff person to CHPG from OA.

**Communication** (in depth discussion).

Communication takes more than one (community).

Opportunity to learn from each other.

To thine own self be true then, you can be true to others.

No fear.

## **7. Technologies/ Data** (initial discussion)

### **Mission:**

To use technology to elicit community and CHPG member involvement.

- Make effective use of CHPG website
  - Post the prevention/care plan

Post SCSN

Use video conferencing in-between planning body meetings.

- Increase community participation via technology.
  - 800 number allows public to call in during designated time.
  - I-chat online.
  - Feature on Web site – e-mail meeting notices/updates.

Have dedicated staff person to maintain/update website.

### **Recommendations: Incorporating Data**

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Incorporate data into planning process.

Use GIS mapping (locally/statewide).

Present data on special populations on an ongoing basis (e.g., quarterly).

- Data Summit – California.
  - Use as a launching pad to shape our response across the state.
  - Use the data to improve our response.

Include data from non-OA-funded entities: colleges; universities; STD info; what interventions work/don't work; understand trends.

Share data with other social services agencies (drug, mental health).

Bringing experts to the table DATA.

Planning around community NEEDS.

- Individuals take responsibility for bringing issues to the table.
- Consequences for not following through.
- OA is at the table – do not forget their expertise.

Focus on expertise here – within the membership - let's use that.

**Technologies/Data** (in depth discussion).

Update CHPG Web site to include:

- Recent HIV/AIDS data (2006) specific to California.
- Trends/special populations and hot spots.
- Minutes/meeting summaries (pdf and audio).
- Links to local health jurisdiction and EMA Web sites (clickable map).
- Podcasts.
- Chat capabilities for online meetings.

Use technology to engage community input.

Public Comment/Questions.

- On CHPG Web site.
- Text/e-mail/Twitter.
- Teleconference/Skype.
- Rapid response to individuals also posted to Web site in "Question and Answer" section.

**USE EXISTING RESOURCES!!!!**

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## 8. Pros and Cons of Community Planning

### Pros

Meeting federal requirements (for care and prevention above and beyond current requirements).

Input across state

- ★ Should represent all populations and diverse communities
- ★ Can give local perspectives on statewide issues and reporting [to feds and governor]

Checks and balances for OA and community process.

Network and develop best practices (sharing of information).

- ★ [Increase] political power.
- ★ Lends credibility [to recommendation affecting the entire state]

Buy-in across state.

Ensures the money goes where its supposed to go.

### Cons

- ★ Not always the right people at the table (recent grassroots experience limited or limited administrative experience).

- ★ Ability to reach consensus in large group.

Routinized process [becomes a never-ending story. Need to start *and complete* a task or charge]

- ★ Looking micro versus macro [individual concerns and passions versus statewide/global concerns]

[No current] quality assurance for process and product [within CHPG as of now].

### Pros and Cons: Recommendations

#### Pros

Limited experience gives a new, fresh perspective.

Allow care and prevention to work together in one place.

Smaller groups can result in more and better input.

More relaxed atmosphere.

#### Cons

- ★ Prior structure too formal/intimidating.
- ★ Communication limited in the formal structure.

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Non-members and OA staff do not participate or interact with larger group and expertise not used.

**Recommendation:** Pros outweigh cons – community planning is of value and should continue.

## 9. Process

Focus on something tangible: statewide plan.

A process to obtain information and data (needs assessments, gaps analysis) to get a picture of what is happening in the state.

Network with local groups (CBOs) like Being Alive in such a way that they are a part of this body, so it is organic.

- We know what groups exist.
- We are the community we're representing so we *are* at the table.

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### 3:30 p.m. Next Steps, Check-out

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At the end of Day Two, CHPG members prioritized what they felt was most important for the design team to address in creating a prototype process and structure(s) to be reviewed and discussed by the entire body at the June 2009 meeting. Each member was given five "dots" which could be placed on any design component or any detailed element discussed over the two days. The result was the attached list of relative priorities, showing the number of dots given to each category and how the dots were distributed among design components.

CHPG membership also shared their initial comments and questions on the small-group recommendations.

#### **What Will Design Team Do?**

1. Review best practices and mission statements of other planning bodies
2. Clarify the second point in the mission statement: "On an annual basis, engage in activities designed to determine that the work of OA is effective in addressing the plan."
3. Meet in May 2009 to design one to three prototype designs that the larger group can discuss and decide upon at a second summit in June 2009.

#### **Comments for Design Team**

1. Consider carefully the vision and mission for community planning, including a broader vision, such as an HIV-free California.
  2. Look at how consumers are involved, how many HIV-positive people are
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engaged in the process.

3. Provide “best practice” data from other states, which includes answers to the question of what is the role of community planning in the state?
4. Consider the decision-making process (e.g., meeting rules/by-laws, quorum, majority/minority).

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**4:00 p.m.     Adjourn**

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