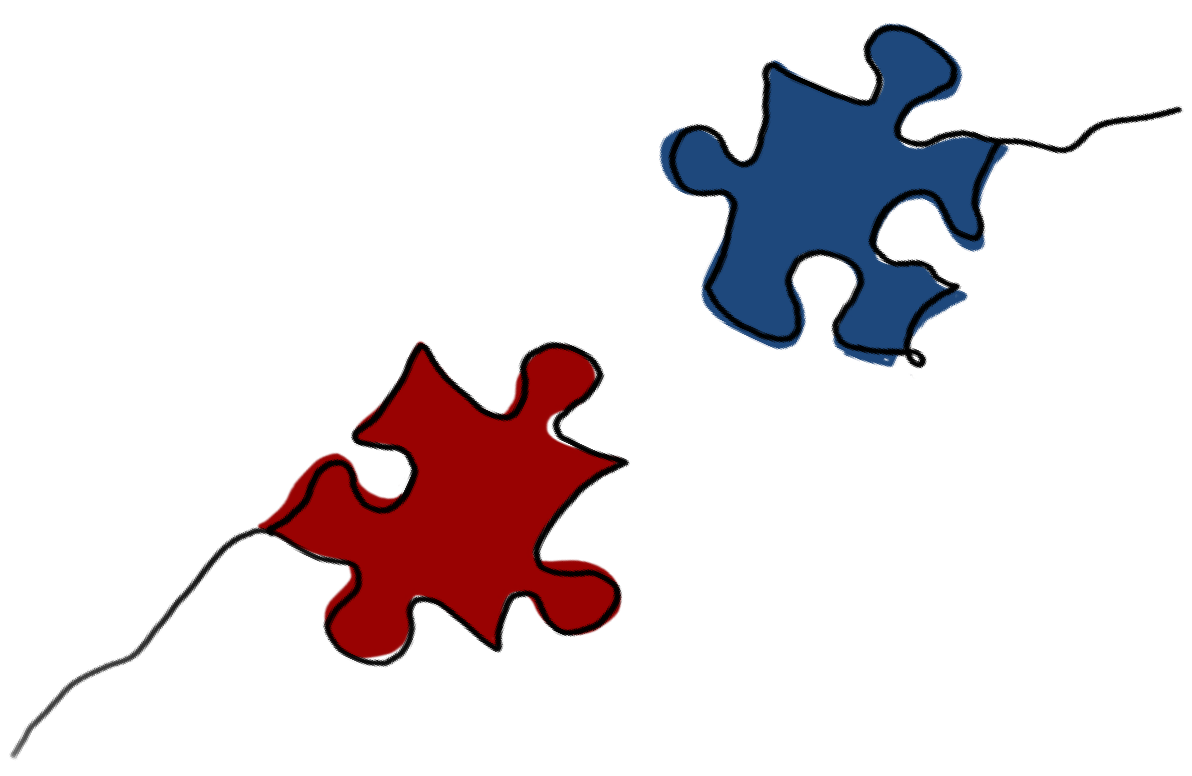
RESULTS AND RECOMMENDATIONS

FROM A SERIES OF STAKEHOLDER CONVERSATIONS TO INFORM THE ESTABLISHMENT OF A LOUISIANA DEPARTMENT OF HEALTH SUBSTANCE USE AND INFECTIOUS DISEASE STEERING COMMITTEE

DECEMBER 2021



The Health Resources and Services Administration-funded Ryan White HIV/AIDS Program Special Projects of National Significance initiative Strengthening Systems of Care for People with HIV and Opioid Use Disorder (OUD) provides coordinated technical assistance across HIV and behavioral health/substance use service providers. The project aims to enhance system-level coordination and networks of care among Ryan White HIV/AIDS Program recipients and other federal, state, and local entities. The purpose of this initiative is to ensure that people with HIV and OUD have access to care, treatment, and recovery services that are client-centered and culturally responsive.

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Acronyms

BRCO	Bureau of Regional and Clinical Operations
CHW	Community health workers
EHE	Ending the HIV Epidemic
FQHC	Federally Qualified Health Centers
HAB	HIV/AIDS Bureau
HCV	Hepatitis C virus
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
JSI	JSI Research & Training Institute, Inc.
LaSOR	Louisiana Statewide Opioid Response
LDH	Louisiana Department of Health
LGE	Local Governing Entity
LODSS	Louisiana Opioid Data Surveillance System
OBH	Office of Behavioral Health
OD2A	Overdose Data to Action
OPH	Office of Public Health
OPOC	Opioid Preparedness Outreach Coordinator
OUD	Opioid use disorder
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SHHP	STD/HIV/Hepatitis Program
SSP	Syringe services program
STI	Sexually transmitted infection
SUD	Substance use disorder
TA	Technical assistance

Executive Summary

This report summarizes feedback provided voluntarily by key individuals in leadership positions in the Louisiana Department of Health (LDH) and Louisiana state government about a potential new LDH Substance Use and Infectious Disease Steering Committee. The facilitated conversations built on previous work and progress under the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) initiative, funded by the Health Resources and Services Administration under their Ryan White HIV/AIDS Program Special Projects of National Significance authority.

Beginning in late 2019, JSI Research & Training Institute Inc. (JSI), in collaboration with NASTAD, convened LDH partners across the Office of Public Health (OPH) and Office of Behavioral Health (OBH) and formed an SSC core working group. In collaboration with the LDH SSC core group, the JSI/NASTAD SSC team developed a landscape analysis report, assessed baseline systems coordination, facilitated regular meetings to identify new opportunities for collaboration, and led discussions with LDH staff to prioritize activities to strengthen system-level coordination and networks of care for people with HIV and opioid use disorder (OUD). From these activities and discussions, the LDH SSC core group requested assistance in exploring the possibility and viability of establishing a new LDH Substance Use and Infectious Disease Steering Committee. The LDH SSC core group recognized the importance of creating infrastructure to support ongoing collaboration. The group postulated that such a committee could effectuate change and chart new directions in leveraging funding and implementing collaborative programs across the intersecting epidemics of HIV, hepatitis C virus (HCV), and substance use, including OUD.

To inform the development of the steering committee, JSI/NASTAD engaged Steven Young as an external consultant to facilitate the feedback calls. The discussions included probing questions across several key domains:

- Agency overview
- Leadership commitment and key staff
- Planning
- Structure
- Activities/roles/responsibilities
- Integrated care model
- Main challenges/gaps
- Solutions/opportunities
- Additional thoughts/questions

Overall, the ten respondents described a general sense that program efforts were in place to assist those affected by HIV and OUD with access to care, treatment, and recovery services, and that they were somewhat coordinated, patient-centered, and culturally responsive. However, there was also recognition that there was both a demonstrated need and opportunity for improvement to effectuate positive health outcomes through more formal collaboration and integration.

The JSI/NASTAD team encourages LDH leadership and staff to consider the recommendations described in this report across the aforementioned domains to determine appropriate action steps. Sequentially however, LDH must first determine that a new Substance Use and Infectious Disease Steering Committee should be established; this report supports that position. Secondly, the organizational position of this new steering committee within the state government must be determined; this report suggests a high-level placement within LDH.

The JSI/NASTAD SSC team has centered the *Five Conditions of Collective Impact*, first described in the 2011 Stanford Social Innovation Review article, *Collective Impact* by John Kania and Mark Kramer of FSG,[1] in the overall project approach. Though the discussion content did not directly correlate to the five conditions in the model, JSI/NASTAD recommends that LDH staff consider the five conditions in establishing the roles and responsibilities of a new steering committee. As such, stakeholder input is summarized and subsumed under the following categories: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support.

Common Agenda – Stakeholders strongly suggested that a new LDH Substance Use and Infectious Disease Steering Committee be established with a diverse membership comprising leaders, program staff, and external stakeholders from across the state, and that this committee develop a vision and mission with a set of goals and objectives to be achieved through collective action.

Shared Measurement – While several data sources were cited by respondents, they also noted that state-level data are primarily aggregate data, which does not facilitate client-level data analysis to describe how unique clients access services across multiple programs. The majority of respondents recognized the value of more comprehensive and shared syndemic data across programs that could help drive decisions and actions serving those with or at-risk for HIV/HCV/OUD. Future data integration efforts may enable analytics to further understand these three interrelated health issues and their collective impact on communities, be used to monitor progress over time, and provide actionable intelligence to inform new directions and programs.

Mutually Reinforcing Activities - The majority of stakeholders reported that while there are examples of good collaboration and communication in specific areas (e.g., collaborations among Medicaid, OPH, and OBH for HCV payment model and performance improvement project; harm reduction programming), overall, consistent and comprehensive efforts across infectious disease and substance use are generally lacking and not implemented at a level commensurate with a forward-thinking integrated approach. Respondents observed that Louisiana has had many well-intentioned programs that have historically been siloed and have been administered and operated in parallel, rather than having been coordinated or integrated. They were however supportive of a new steering committee establishing a common set of goals

[1] John Kania and Mark Kramer. "Collective Impact," Stanford Social Innovation Review, 2011. ssir.org/articles/entry/collective_impact.

and objectives to facilitate integrated models of prevention and care, the establishment of uniformity and service standards across the state supporting integrated care models, and a continued review of public and private funding/reimbursement sources. A key component of early work would be to look at the coordination of various funding streams and a potential "braided funding" approach to support integrated programs.

Continuous Communication – Respondents discussed challenges working together as a cohesive group, including communication, organizational/programmatic/provider cultural barriers, and biases. They noted that the group must also adopt a view that any new efforts are seen as an improvement opportunity, void of criticism directed toward individuals or programs. Respondents affirmed the critical role of external stakeholders, community members, and people with lived experience in state planning processes across HIV, HCV, and OUD. They mentioned the importance of both provider involvement and formal, local input into state-level planning bodies. Respondents described external stakeholder engagement as a central tenet of state planning efforts and a critical responsibility for a new LDH Substance Use and Infectious Disease Steering Committee. Participating individuals also expressed that the recent experiences of working through COVID and weather impacts were valuable in learning how to continuously communicate and disseminate information through social media and remote interactions.

Backbone Support – Limited resources (available staff, time, and funding) are currently seen as a major challenge to collaboration across systems. A review of successful groups, committees, councils, and comprehensive plans in Louisiana may provide insight into potential structures that support a sustainable steering committee. Backbone support in the collective impact model provides infrastructure and processes to guide vision and strategy. For the SSC project, the JSI/NASTAD team has served this function in each of the participating states. However, a sustainable steering committee will require responsible parties to build public will, convene and facilitate the group, manage logistics, mobilize funding, and advance group goals.

Respondents noted that a steering committee that is situated properly within the state government structure with dedicated resources, high-level representation, and diversity in membership and lived experience provides multiple opportunities. Participating individuals described that the timing is appropriate to lean on champions, mobilize enthusiasm to refocus efforts on activities not related to the COVID response, incorporate the perspective of individuals and communities most affected, and engage providers on the ground to further networks of care for people with HIV and OUD.

Background

The Ryan White HIV/AIDS Program (RWHAP), first authorized by the U.S. Congress in 1990, is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). The RWHAP is critical to ensuring that low-income uninsured or underserved people with HIV are linked to medical care, retained in medical care, prescribed antiretroviral medications, and achieve and maintain viral suppression.

Through the HRSA-funded RWHAP Special Projects of National Significance initiative, Strengthening Systems of Care for People with HIV and Opioid Use Disorder (referred to as 'SSC' going forward), JSI, in partnership with NASTAD, has been funded to work with Louisiana and eight other states. SSC aims to enhance system-level coordination and networks of care among RWHAP recipients and other federal, state, and local entities to ensure that people with HIV and OUD have access to care, treatment, and recovery services that are coordinated, patient-centered, and culturally responsive. The JSI/NASTAD SSC team provides coordinated technical assistance (TA) across HIV and behavioral health/substance use services systems and providers.

In the early months of the SSC project, the JSI/NASTAD team worked with the LDH SSC core group to complete a landscape analysis report describing: 1) an epidemiological profile of HIV and OUD in Louisiana; 2) funding for HIV and OUD in Louisiana; 3) relevant state agencies, stakeholder groups, legislation, and policies; 4) systems of care for HIV and OUD service provision; and 5) TA and training providers. The final section summarized strengths and opportunities to inform systems strengthening efforts. This report served as a foundational tool for the SSC project in Louisiana, providing critical information for the development of TA and evaluation plans, and is a continuing resource for project activities throughout the three-year project period (September 2019–August 2022). The landscape analysis report captured a snapshot in time (June 2020) in a changing and evolving landscape and has provided overall context for the ongoing work.

JSI and NASTAD also worked with the LDH SSC core team and administered a *Systems Coordination Tool for HIV and Opioid Use Disorder*, which was designed to measure the baseline level of systems integration and coordination among various key components of HIV/OUD systems. This assessment yielded low-to-medium and low ratings across twelve coordination categories, with two identified as the most important priorities:

- Development of goals and objectives to address coordination of HIV and OUD programs
- Coordination of state and federal funding for HIV and OUD programs/services

Through ongoing SSC activities and regular meetings of the LDH SSC core team, LDH staff had begun to identify opportunities to strengthen coordination and collaboration across offices, as well as the integration of HIV, HCV, and behavioral health programs. However, the LDH core group also recognized the importance of creating infrastructure that supports ongoing collaborations, rather than depending on individual relationships, and requested assistance in exploring the possibility of establishing a new LDH Substance Use and Infectious Disease Steering Committee. The group postulated that such a committee could effectuate

change and chart new directions in leveraging funding and implementing collaborative programs across the intersecting epidemics of HIV, hepatitis C virus (HCV), and OUD.

The LDH SSC core group acknowledged the need for additional input and buy-in from key stakeholders across LDH and state government to assess the viability and inform the development of a new steering committee. JSI/NASTAD engaged Steven Young as an external consultant to conduct a series of virtual structured conversations with key stakeholders via Zoom meetings.

The LDH SSC core group prepared an internal briefing document for LDH leadership (see Appendix A) and received approval to conduct a series of stakeholder discussions. Initially, sixteen state leaders were identified as potential key stakeholders. Given the concurrent and ongoing demands of the COVID-19 response and impacts from storms during the fall of 2021, the project was limited to the completion of ten discussions. OPH STD/HIV/Hepatitis Program (SHHP) leadership confirmed that the final group of ten however provided satisfactory representation across LDH and offered sufficient input to move forward with recommendations for the proposed steering committee.

The purpose of the conversations was to elicit thoughts, using a structured set of discussion questions (see Appendix B) conducted by an external consultant, about current planning, programming, and coordination efforts by the state of Louisiana to address the needs of people who use drugs and the impact of related epidemics (HIV, HCV) on communities. The responses were used to prepare this summary report and inform recommendations for a proposed LDH Substance Use and Infectious Disease Steering Committee.

Methodology

Discussion guide

The external consultant, in collaboration with JSI/NASTAD, drafted and finalized a discussion guide, with review and input from the LDH SSC core group. SHHP leadership coordinated with the OPH Assistant Secretary to distribute the internal briefing document and invite identified stakeholders to participate in the discussions. JSI scheduled 45-minute discussions with key individuals possessing expertise and decision-making authority related to HIV, HCV, and OUD programming, planning, policy, legislation, and financing. All participation was voluntary, with an opt-out clause for any particular question that a participant could not or did not want to answer.

The conversations were confidential, and the thoughts and recommendations shared and put forward in this report are not associated with any one individual. Additionally, LDH SSC core group members had an opportunity to respond to the same questions during a monthly call and provide additional input to inform recommendations. The JSI/NASTAD team took notes and recorded the conversations for internal review, if needed to clarify the notes.

The external consultant reviewed and analyzed all notes from the discussions and compiled common themes. As the number of discussions was limited and the guide consisted of open-ended questions to facilitate conversation and thought, the resulting findings are qualitative in nature.

The discussion guide included probing questions in several key domains:

- Agency overview
    - Organization/office roles in reaching and serving the populations of focus
    - Current view of collaboration and communication across programs/services
    - Gaps that could be addressed by a new committee
- Leadership commitment and key staff
    - Integration and collaboration
    - Successful committees or structures to address cross-cutting health issues
- Planning
    - Planning activities and funding opportunities for HIV, HCV, and OUD
    - Existing plans
    - Data availability and sharing
    - Input from external stakeholders, particularly people with lived experience who access services
- Structure
    - Organizational placement of a new committee
    - Bylaws, policies, and procedures
- Activities/roles/responsibilities
    - Recommended responsibilities

- Integrated care model
    - Community level
    - Actualization and support through a new committee
- Main challenges/gaps
- Solutions/opportunities
    - Address gaps and challenges
    - What could happen through a new committee
- Additional thoughts/questions
    - Public health planning and response – lessons learned through COVID
    - Other

This report summarizes key themes and overall trends from the stakeholder discussions. The intention of this process was not to come to consensus, but to gather feedback and input from a diverse group of leaders within LDH and state government, and to use that input in considering how best to effectuate change and chart new directions in collaborative programming across the intersecting epidemics of HIV, HCV, and OUD.

Collective impact

The JSI/NASTAD SSC team has centered the *Five Conditions of Collective Impact* (see figure 1), first described in the 2011 Stanford Social Innovation Review article, *Collective Impact* by John Kania and Mark Kramer of FSG,[2] in the overall project approach. Although the discussion content did not directly correlate to the five conditions in the model, JSI/NASTAD recommends that LDH staff consider the five conditions of collective impact in establishing the roles and responsibilities of a new steering committee: ***common agenda, shared measurement, mutually reinforcing activities, continuous communication,*** and ***backbone support***.

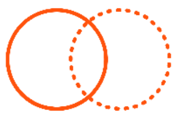
[2] John Kania and Mark Kramer. "Collective Impact," Stanford Social Innovation Review, 2011. ssir.org/articles/entry/collective_impact.

Figure 1.

Five Conditions of Collective Impact

Common Agenda
All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.

Shared Measurement
Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.



Mutually Reinforcing Activities
Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.

Continuous Communication
Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation.

Backbone Support
Creating and managing collective impact requires a dedicated staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

Source: FSG

The findings in this report are organized according to the aforementioned domains in the discussion guide. The external consultant and JSI/NASTAD team gleaned information from the ten stakeholder conversations and LDH SSC core team input to develop recommendations for the structure, support, and potential activities/responsibilities of a LDH Substance Use and Infectious Disease Steering Committee. Throughout the document, icons reflecting the collective impact conditions indicate relevant recommendations. All recommendations are also synthesized in a final recommendations section.

Findings

Agency Overview – Organization/Office Roles

Stakeholders represented a spectrum of LDH offices and units (i.e., four stakeholders from OPH, four from OBH, one from the Bureau of Health Services Financing), as well as the Governor's Office of Drug Policy (one stakeholder). Though small in overall numbers, this group of leaders represented a healthy cross-section of high-level leadership/management, program, policy, data, and community engagement functions. They shared their experiences and perspectives gained from working in OBH related to mental health and substance use prevention and treatment; OPH with a focus on HIV, HCV, sexually transmitted infections (STIs), and surveillance operations; and health informatics. Additional perspective was also gleaned from current and past experiences and relationships that participants had with staff in the Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, housing services, and Medicaid. Respondents included key professionals in the Governor's Office of Drug Policy, OPH's Office of Legislation and Policy, and those serving on the Louisiana Commission on HIV, AIDS, and Hepatitis C Education, Prevention, and Treatment.

Agency Overview – Current View of Collaboration and Communication

In considering the intersection of HIV, HCV, and behavioral health/substance use, the majority of participants reported that while there were examples of good collaboration and communication in specific areas (e.g., collaborations among Medicaid, OPH, and OBH for HCV payment model and performance improvement project; harm reduction programming), that overall, consistent and comprehensive efforts were generally lacking and not at a level commensurate with a forward-thinking integrated approach. Some individuals offered a more positive, yet narrowly defined, view of collaboration and communication. Such responses appear limited to the individuals' areas of responsibility rather than consideration of a wider lens. Positive examples cited were in the areas of individual relationships across offices, and since initiating the SSC project, mutual development of programs through the Substance Abuse Prevention and Treatment Block Grant and American Rescue Plan Act of 2021, and sharing funds through Louisiana State Opioid Response (LaSOR) grant.

Two issues emerged as an overlay to the challenges facing Louisiana state officials in their efforts to effectively collaborate and communicate. The first is the inability to consolidate, merge, and share available data (from several excellent, yet independent data systems) to further analyze and monitor the status of HIV, HCV, and OUD, and their collective impact on priority populations. The second is the regional organization of programs, which creates challenges in making state-level changes given the balance of regional/local control in spending and programming by the LGE; and both the northern/southern geographic divide and New Orleans and Baton Rouge metro/rural divide, which require varied and nuanced approaches across the state.

Agency Overview – Gaps for a New Committee to Address

Half of the respondents indicated that a new committee could be instrumental in addressing organizational issues that have prevented full integration and collaboration across the three focus areas (i.e., HIV, HCV, OUD).

It was suggested that high-level involvement was critical to help with overall direction of new efforts and activities, and that this should be balanced by the participation of program staff working on the ground with diverse communities. With Medicaid being a primary payment source for many services, stakeholders stressed the importance of engaging Medicaid officials as partners early in the initial discussions and development of any new initiatives. There was also some sentiment expressed that a steering committee could facilitate development of policies and processes to hold partners and Local Government Entities (LGEs) accountable to better integrate services and meet the needs of communities.

Several respondents specifically mentioned a gap related to the need for substance use disorder (SUD) clinics and programs treating OUD to more effectively address harm reduction and intersecting stigma, and screen for HIV, HCV, and STIs. SUD settings also must be ready when individuals make the decision to seek assistance and ensure a variety of coordinated services are available to meet their diverse needs.

It was also suggested (and wished for) that a new committee might help manage the pressures of dealing with COVID, natural disasters, and OUD, the first two of which have necessitated transfers in responsibility and have been all-consuming for staff. Respondents recognized that historical funding silos have limited opportunities for crossover and integration of infectious disease services in substance use prevention, care, and treatment services, and vice versa. Similarly, current planning efforts across infectious disease (e.g., Ending the HIV Epidemic [EHE] initiative) and SUD both involve a prevention focus, but activities and messaging are not coordinated or amplified.

Leadership Commitment and Key Staff – The Meaning of Integration and Collaboration

Responses were split between those who offered definitions for integration and collaboration and those who responded with examples. Collaboration was generally seen as "people" working together toward a common goal, and thus meeting the needs of diverse and under-resourced populations. Integration was defined as "programs" working together effectively in utilizing available resources; it was recognized that such integration was sometimes forced by executive decision and sometimes was voluntary and organic.

The examples of integration and collaboration that respondents provided included syringe services programs (SSPs) partnering with OBH to distribute naloxone and provide harm reduction and recovery support services, the role of Medicaid and strategic SUD planning, and medical providers and clinics providing mental health and SUD screening.

Finally, it was observed that Louisiana had many well-intentioned programs that historically have been siloed and have been administered and operated in parallel, rather than having been purposefully coordinated or integrated.

Leadership Commitment and Key Staff – Successful Steering Committees or Structures

All respondents offered specific examples of potential committees or structures to serve as examples, but no one entity emerged as a preeminent model. Respondents affirmed the Advisory Council on Heroin and Opioid

Prevention and Education (HOPE) and Integration of Primary Care and Behavioral Health Committee (prevention lens) as successful groups. The HOPE Council has state legislative authority and is seen as a good model for a working group to address a challenging issue and bring back recommendations to the Council for action.

Other steering committees and structures included:

- Drug Policy Board
- Louisiana Commission on HIV, AIDS, and Hepatitis C Education, Prevention, and Treatment
- Louisiana Behavioral Health Advisory Council
- Homeless Alliance Committee
- Coordinated System of Care Governance Board
- Louisiana Commission for the Deaf

SHHP has provided staff support for the Louisiana Commission on HIV, AIDS, and Hepatitis C Education, Prevention, and Treatment, and works with local advisory boards on implementation of SSPs.

Planning – Activities and Responses to Funding Opportunities

In describing planning activities related to funding opportunities, several respondents mentioned SHHP planning efforts, as well as the use of HIV set-aside funds in the Substance Abuse Prevention and Treatment Block Grant for early intervention services at SUD sites. Most recently since the start of the SSC project, joint planning, particularly related to pre-exposure prophylaxis (PrEP) and SSPs, now occurs related to the LaSOR grant, RWHAP, Centers for Disease Control and Prevention grants, and the American Rescue Plan Act funds.

Medicaid expansion has been extremely successful in increasing access to care and services in the state, but overall, Medicaid staff involvement appears limited in terms of federal grant planning for HIV, HCV, and SUD. Letters of support are often provided across programs and organizational units but do not necessarily include proactive/joint planning up front.

Planning – Existing Plans

Two resources were specifically mentioned that could have utility for a new LDH Substance Use and Infectious Disease Steering Committee. The HOPE Council has a strategic plan that outlines areas of focus, and there is a Substance Use Prevention Strategic Plan. Various applications for federal funding include plans and logic models, and organizationally, LDH has a strategic plan. While a new steering committee may or may not develop their own plan, it is suggested that a review of existing plans might help inform their priorities and activities.

Planning – Data

In discussing potential data sources to support steering committee efforts, respondents universally mentioned the richness of Medicaid and program data, along with the acknowledgement and frustration that data were not combined from different sources into a single, unified view that would allow for analysis of HIV/HCV/OUD

programming and their impact on individuals served. Surveillance data (e.g., overdose, OUD treatment, HIV) across programs and systems are maintained by separate entities. Future data integration efforts could ultimately enable analytics to produce effective, actionable intelligence about new directions and programs.

Select respondents mentioned specific data sources to drive activities including Medicaid dashboards that provide information on medications for OUD, HCV treatment, and quality measures; overdose surveillance dashboard; HCV surveillance efforts (as part of the HCV Elimination Plan). Fewer respondents mentioned OPH data inclusive of emergency room and hospital admissions, HIV surveillance data, and RWHAP client-level data. Other data sources included OBH OUD data reported by LGEs, as well as treatment data.

Aggregate state-level data do not permit analysis on unique clients served across multiple programs. The majority of respondents recognized the value of more comprehensive data across programs and disease entities that could help drive decisions and actions serving those with or at-risk for HIV/HCV/OUD.

Planning – External Stakeholders

Respondents affirmed the critical role that external stakeholders and people with HIV and HCV play in state planning processes, with improvement needed in terms of the involvement of people with lived experience of OUD. There is also a move within the state to hire individuals with lived experience as staff – peer workers, community health workers (CHWs), disease intervention specialists, etc.

A few respondents mentioned the importance of provider involvement, and others cited examples of formal local input into state-level planning bodies. External stakeholder engagement appears to be a central tenet of state planning efforts and will be critical for a new LDH Substance Use and Infectious Disease Steering Committee.

Structure - Organizational

While the integration of HIV/HCV/OUD programs could occur organically, a key component for the establishment and sustenance of new efforts is a formally recognized body situated at a level that transcends individual disease programming. Most respondents indicated that a new steering committee should operate organizationally at a high level within the LDH. This would assist in addressing cross-cutting issues and could be led by the State Health Officer out of the Office of the Secretary. Discussion was also put forward related to health equity and community engagement; one respondent mentioned placement at a specific office level. Instead of suggesting OPH or OBH (two primary program units), the more neutral yet important Office of Community Partnerships and Health Equity was suggested for consideration.

Two respondents indicated that a new steering committee should be situated within the Office of the Governor to gain public notice and traction on key issues.

Structure – Bylaws, Policies and Procedures

Functional committees require effective bylaws, policies, and procedures. Several respondents discussed the possibility of utilizing or emulating those already in existence via other groups, such as the LDH itself or Drug Policy Board (of which the HOPE Council is a subcommittee). It was also suggested by several respondents that such written operational documents should clarify the role of the new steering committee as distinct from other Committees or Commissions or specify how its work might be incorporated into the work of others. This new steering committee and its codifying documents must clarify its unified approach across multiple health issues and levels of state/local programs around a singular focus.

Several respondents described the need to focus on membership requirements. The range of input included concepts of appointment authority, regional and non-LDH representation, and a diverse perspective from individuals with lived experience. The inclusion of lived experience was seen as particularly critical, combined with programmatic subject matter experts and high-level leadership to help inform new projects and models that could cut across disease domains. One respondent felt strongly that it was important to avoid a legislative mandate and the resulting potential for political interference.

A few of the respondents discussed process requirements for regular and remote meetings, proxy possibilities, and respect for Health Insurance Portability and Accountability Act (HIPAA) and Substance Abuse and Mental Health Services Administration (SAMHSA) regulations and boundaries. Also mentioned was the need to establish a strong relationship with LGEs given that they operate independently, and potential reframing of their contract and reporting requirements to promote delivery of HIV, HCV, and STI screening.

Structure – Activities, Roles, and Responsibilities

Several respondents recommended that a new steering committee should focus on high-level policy issues and system-level change, and work with the Office of the Secretary as their champion. It was expressed that

input for policy should emanate from programmatic staff who are closer to on-the-ground work with community partners. This would help reduce siloes and ensure policies respond to real issues for populations affected by HIV/HCV/OUD.

Half of the respondents stressed the importance of developing a vision and mission statement for the new steering committee, which would drive all activities including the coordination of grants and other funding opportunities. There was a concern about spending too much time fine tuning and creating a vision and mission statement at the expense of moving forward with actionable items. However, based on such language, it was felt that actionable items and objectives could then be developed, inclusive of high-level leaders, community workers/providers, program staff, and people with lived experience.

Respondents shared additional responsibilities that could be assumed by a new steering committee:

- Create a statement of rights for people with HIV, HCV, and OUD.
- Educate and train local government officials toward an expansive understanding of SUD, including the holistic health and social needs of people with SUD and the continuum of services that could benefit people with SUD.
- Foster further integration of HIV services into primary care and SUD programs.
- Coordinate data collection/data sharing and analysis across HIV/HCV/OUD.
- Develop, plan, and organize a braided funding approach to programming.
- Strengthen the OBH and OPH working relationship.

Two respondents suggested conducting a more comprehensive assessment of need to pinpoint priorities for the program integration.

Integrated Care Model

Feedback describing a community-based model of integrated care was evenly split across two viable and well-established (in other state and local jurisdictions) approaches. The first is a "one-stop shop" model with full on-site integration of behavioral health, primary care, and HIV/HCV/STI services, using an interdisciplinary care team comprising medical providers, case managers, peer specialists, screening and testing professionals, CHWs, and other support staff. Federally Qualified Health Centers (FQHCs) and primary care clinics offer potential settings for this approach.

The second approach is a "no-wrong-door" model with a menu of service provider options as opposed to one single site. Entry into the "system" would facilitate referral to and service provision by multiple accessible and culturally appropriate providers. The no-wrong-door approach is also recommended in NHAS: *Strategy 4.1.2: Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.*

Other thoughts supportive of an integrated care model included the establishment of uniform service standards across the state, along with a continued look at Medicaid as a reimbursement source.

Integrated Care Model – Steering Committee Role

Respondents uniformly expressed that a new steering committee would help foster an integrated care model for people who use drugs and are at-risk for or who have HIV or HCV. The steering committee could help by:

- engaging FQHCs, the Louisiana Primary Care Association, and other primary care providers and incorporating their input;
- promoting integration across substance use and infectious disease services and programs;
- examining opportunities for staff to assume new roles with specific responsibilities around integration and coordination;
- developing braided funding strategies;
- focusing on efforts statewide to bridge the geographic divides; and
- preparing an analysis that makes a financial case for integration and positive health outcomes.

Challenges were seen, however, in breaking down existing barriers of provider culture, practices, and training. As with many groups, ongoing commitment and engagement is a potential challenge. Sustaining interest, initiative, and energy among members is key, which may relate to whether individuals are assigned/directed to participate versus volunteering to serve on the steering committee. Initiative and energy within its membership, and whether individuals were assigned/directed or volunteered for the steering committee was seen as a critical factor.

Main Challenges and Gaps

Respondents provided varied feedback as to what they saw as the main challenges and gaps facing a new steering committee. Several discussed the issue of overcoming the status quo and staff exhaustion (due to COVID), as well as incorporating new staff and providing for an external perspective.

Some discussed challenges in working together as a cohesive group and the need to work through communication and cultural barriers, as well as biases, and focus on the critical nature of what should be seen as an "improvement opportunity," void of criticism directed toward individuals or programs. Others were concerned about the make-up needed for the group to be effective with the right leadership and a clear niche and goals.

Resources (available staff, time, and money) and cross-program data availability/analysis were also seen as major challenges.

Solutions and Opportunities

Half of the respondents believed that the establishment of a new steering committee would provide the opportunity to move forward to strengthen systems of care across substance use and infectious disease. They felt it would provide an opportunity outside of the COVID response to conduct open and proper planning across programs, recruit and lean on a few champions, refocus programs based on the lens of those with lived experience, and connect with providers engaged on the ground.

A couple respondents mentioned the opportunity to include and build on peer support efforts, engage more effectively with Medicaid, and build upon the coordinated work related to the Medicaid HCV subscription treatment model.

One respondent specifically thought it made sense to "nest" the new steering committee within the HOPE Council, given its success in their work with OUD, and add the components of HIV and HCV programming.

Additional Thoughts and Questions – Lessons Learned from COVID

Respondents were asked to consider the public health response to COVID and potential lessons learned that could be applied to a new LDH steering committee. Feedback was provided in four areas:

- Telehealth – Telehealth was effective in helping provide care and improve communications between providers and patients, as well as bridging the north/south divide in service provision. Third-party reimbursement also supported service delivery.
- Communications – The use of Zoom and social media platforms supported regular engagement and the dissemination of information.
- Leadership and legitimacy - State government leadership led the COVID response by following the science. Given the politics associated with COVID, some at the community level now question the public health role.
- Connection with community – There are always opportunities to incorporate new strategies and improve efforts to reach and serve populations with and at risk for HIV, HCV, STIs, and SUD.

Overall, respondents felt that the COVID response was a good example of how to address an emerging issue at a high level and then develop tactical teams for intervention.

Solutions and Opportunities – What Should Happen?

Most respondents were hopeful that establishing new approaches and creating a more integrated and better coordinated service delivery system would result in positive health impacts for priority populations and diverse communities.

Others focused on the higher-level establishment of a vision, strategy, plan, and actionable activities. There was also reference to the need for a concerted effort to address stigma and incorporate the social determinants of health by developing new policies and implementing activities that may fall outside of typical funded activities under federal grants.

Additional Thoughts and Questions

Two primary items deserving consideration arose in the final conversation. The first is the issue of workforce development and how Louisiana state government can support public health aims to improve health outcomes through training, skill development, and performance of public health workers, behavioral health providers, and medical providers. Somewhat related to this issue, is the involvement of colleges and

universities, not only in the education and preparation of a skilled workforce, but also in terms of other expertise such as community planning, research, and data analysis.

If there is to be a legislative mandate for a new LDH Substance Abuse and Infectious Disease Committee, it would be incumbent to look at the requirements and processes utilized by the OPH legislative/policy office to produce, sponsor, and process such an activity.

Additionally, in this concluding segment of the discussion, respondents reinforced the importance of cross-sectional input, community engagement, and a response to real needs, and efforts/actions based on shared responsibilities.

Recommendations

As previously noted, the external consultant and JSI/NASTAD team gleaned information from the ten stakeholder conversations and the LDH SSC core team to develop recommendations to inform the structure, support, and potential activities/responsibilities of a LDH Substance Use and Infectious Disease Steering Committee. The recommendations in this section are organized according to the five conditions of collective impact as they provide a helpful framework when considering the role, purpose, and function of a steering committee.

- Common agenda
- Backbone support
- Shared measurement
- Mutually reinforcing activities
- Continuous communication

Necessary pre-conditions

Additionally, to confirm organizational commitment and make a decision about the feasibility of a new LDH Substance Use and Infectious Disease Steering Committee, JSI/NASTAD recommends that LDH consider the three pre-conditions for collective impact:

- **Urgency of issue**
    - Affirm the case for enhanced systems-level coordination across infectious disease and substance use funding, programs, and services in response to the ongoing syndemic of HIV, STIs, viral hepatitis, and substance use in the context of social and structural/institutional factors including stigma, discrimination, and violence.
- **Influential champion(s)**
    - Identify champions to demonstrate commitment to the initiative and who have the authority to mobilize resources and drive decisions.
- **Adequate resources**
    - Allocate staff and financial resources to demonstrate commitment and ensure a sustainable and functional body.

Common agenda

Purpose/charge

In support of the National HIV/AIDS Strategy for the United States 2022–2025 (NHAS) Strategy 4.1.3: *Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic of [HIV, STIs, viral hepatitis, and substance use and mental health disorders]:*

- Establish an LDH Substance Use and Infectious Disease Steering Committee. *Recommendations for the structure, composition, and roles are in the sections that follow.*
- Clarify the role of the new steering committee as distinct from other committees or commissions, or how its work might be incorporated into the work of others.
  - Review existing strategic plans to inform priorities and activities (e.g., HOPE Council Interagency Heroin and Opioid Coordination Plan, Louisiana Substance Abuse Prevention Strategic Plan 2017-2021; LDH FY 2017-2022 Five-Year Strategic Plan).
    - *SSC resource: Louisiana Crosswalk: HIV, HCV, OUD, and SUD initiatives, which included the following:*
      - *SHHP/OBH resource: OPH-OBH Harm Reduction Crosswalk*
      - *Hep C Free Louisiana, Louisiana Hepatitis C Elimination Plan: 2019–2024*
      - *Louisiana's Opioid Response Plan*
      - *SHHP resource: EHE plan crosswalk*
        - *Get Loud Louisiana Ending the Epidemic Plan 2021-2025*
        - *Orleans Parish Ending the HIV Epidemic Plan*
        - *East Baton Rouge Parish Ending the HIV Epidemic Plan*
- Develop a vision and mission statement for such a new steering committee.
  - In developing the mission, recognize that LDH is one organization with one goal to ensure care for all citizens of Louisiana, while office cultures and approaches to integrated and whole-person prevention and care may differ.
  - Connect vision and mission to concrete activities, such as grant proposals and funding coordination.

Backbone support

Organizational structure

- Establish the steering committee at a high level within LDH to demonstrate an ongoing commitment to integrated care and services across substance use and infectious disease, ensure actionable activities, provide dedicated resources, and to promote continued engagement. Situating the steering committee in LDH and not in the Office of the Governor supports continued work even as priorities change with new administrations.
  - Within the LDH organizational infrastructure, potential locations include:
    - **Office of the Secretary** to address cross-cutting issues and mobilize necessary resources
    - **Deputy Secretary** given oversight of LDH offices and human services authorities
    - **Office of Community Partnerships and Health Equity** to ensure alignment with LDH health equity strategies and practices
    - **LDH Medical Director and State Health Officer** given the role consults on issues related to policy, programmatic implementation, quality, and accessibility of care

Composition/Representation

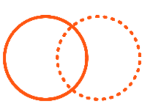
- Steering committee memberships should be diverse and inclusive of high-level LDH leadership with decision-making authority; program staff who understand the logistics and challenges of implementation, as well as community needs; subject matter experts; external stakeholders from across the state; and people with lived experience who provide meaningful input and feedback.
    - Additional potential stakeholders
        - Regional representation (LGEs)
        - Providers - Louisiana Primary Care Association, federally qualified health center staff, SUD, and behavioral health providers

- Consider engaging other LDH offices and programs including:
    - Office of Aging and Adult Services (OAAS)
        - NHAS 2022-2025 describes the unique social, mental health, and physical health needs of **people aging with HIV** and calls for multi-sectoral approaches and strategies to deliver whole-person care and support individuals to obtain optimal health.
        - The steering committee would also benefit from **Permanent Supportive Housing** (PSH) program representation.
    - Office of Community Partnerships and Health Equity
        - Ensure alignment with and incorporate strategies from the **LDH health equity plan**.
        - Include representation from the statewide advisory board to inform steering committee activities in the context of **health equity practices, protocols, and results.**
    - Bureau of Health Services Financing (Medicaid)
        - Engage Medicaid officials as partners in the initial discussions and development of any new initiatives.
    - OPH Bureau of Health Informatics
        - Examine confidentiality restrictions and facilitate data sharing across programs and departments.
- Identify strategies to promote and sustain ongoing engagement.
    - Consider motivations for membership in determining steering committee composition.
    - Include a mix of members who volunteer to participate given their interests and who express high levels of enthusiasm, and those who are appointed because of their position or decision-making authority.

Shared measurement

- Identify opportunities to coordinate data collection, data sharing, and analysis across HIV, HCV, SUD/OUD programs.
    - Identify the data indicators across HIV, HCV, and OUD programs that will foster shared planning, resource allocation, and integrated service implementation.
    - Identify data points that can be leveraged to inform statewide planning efforts across the syndemic of HIV, STIs, viral hepatitis, and SUD/OUD.

    - Establish processes for routine data sharing.
    - Review syndemic data regularly to identify new opportunities for collaboration.
- Establish uniform service standards across the state to support an integrated HIV, HCV, and SUD/OUD care model.
    - Develop common HIV and HCV service measures to incorporate into OBH LGE contracts and OPH SHHP contracts.
- Develop a data dashboard to elevate and disseminate information collected from regional and LGE activities to inform state priorities.



Mutually reinforcing activities

Potential activities/responsibilities

- Review new projects and staffing from multiple levels (i.e., both high-level and program level) to avoid duplication of efforts, create efficiencies, and inform opportunities.
    - Identify opportunities to leverage staff and resources across programs (e.g., peers in emergency departments, infectious disease testing staff, community-based organizations).
- Examine funding streams to identify a potential "braided funding" approach to support integrated programs for people with or at risk for HIV who use drugs.
    - *SSC resource: preliminary SSC funding matrix*
- Establish department-wide expectations and protocols to support a low barrier, no-wrong-door approach to HIV, HCV, and SUD/OUD services.
    - Analyze gaps in service delivery across HIV, HCV, and SUD/OUD and across geographic areas.
    - Examine opportunities for integration to ensure that individuals across the state have access to the same level of services.
        - Foster integration of HIV and HCV services into primary care and SUD settings, including opt-out HIV/HCV testing in opioid treatment programs (OTPs) and other SUD settings overseen by LGEs.
        - Identify opportunities to integrate access to SUD/OUD treatment in RWHAP settings.
- Incorporate a comprehensive drug user health framework that centers the need for holistic care and services for people affected by SUD/OUD.
    - Create a department-wide drug user health value statement, which might include a statement of rights for people with HIV, HCV, and SUD/OUD.
    - Educate and train local government officials toward an expansive understanding of the syndemic of HIV, STIs, viral hepatitis, and substance use in the context of social and structural/institutional factors including stigma, discrimination, and violence.
    - Implement standardized syndemic training requirements for program staff across HIV, HCV, and SUD/OUD.
- Identify system and structural level approaches to reduce intersectional stigma, including policy development.

- *SSC resource: Interrupting Stigma: A Conceptual Map Depicting Stigma Pathways & Intervening Strategies at the Intersection of HIV and Opioid Use Disorder*

Continuous communication

- Inventory reporting and information sources for HIV, HCV, SUD, and OUD services (e.g., provider reports to specific programs, program meeting notes, LGE reports) and develop mechanisms (e.g., dashboard) to promote broader information sharing across programs and stakeholders to inform intersectional statewide efforts.
- Develop mechanisms to routinely engage a broader group of external stakeholders outside of the steering committee membership to obtain meaningful input (e.g., statewide harm reduction community advisory board).
- Establish regional collaborative/coordination meetings for OBH and OPH-funded HIV, HCV, SUD, and OUD program staff.

Appendix A
Internal Briefing Document

LDH Substance Use and Infectious Diseases Steering Committee

WHY: Between 2019 and 2020 drug deaths in Louisiana increased by 43% and synthetic opioid poisoning rose by 104% (LDH Bureau of Health Informatics). Additionally, in 2019 people who inject drugs (age 39 years and under) accounted for 36% of hepatitis C diagnoses in Louisiana as well as 10% of new HIV Diagnosis (LA HCV Surveillance Data, LA HIV Surveillance Data. Communities disproportionately affected by intertwined hepatitis C, substance use disorder, overdose, and HIV epidemics are in need of integrated programs to maximize the effectiveness of opioid and infectious disease prevention efforts. To this end, this group will work to improve intragovernmental collaboration to enhance opioid and infectious disease service provisions to include opt-out HIV/HCV testing in opioid treatment programs (OTP) and local governing entities (LGEs), increased access to naloxone for people at highest risk of overdose, and braid funding to support services offered, as well as a public facing harm reduction and/or substance use marketing campaign to increase awareness among vulnerable communities and direct them toward needed services.

HOW: LDH has partnered with JSI Research & Training Institute, Inc. and NASTAD through the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project to hire an external consultant. Steven Young will conduct key informant interviews and hold discovery meetings with LDH staff to develop evidence-based recommendations and a pathway to create an LDH Substance Use and Infectious Diseases Steering Committee. These findings will be critical to bring to scale ongoing collaboration, engagement, and decision making to build a statewide integrated care model that increases access to harm reduction services for people who use drugs (PWUD).

WHAT: LDH staff members currently working with NASTAD and JSI on the SSC project have collaborated with the consultant to identify potential candidates to participate in key informant interviews from July 12, 2021 to July 23, 2021. The consultant will hold confidential agency discovery meetings to identify challenges to collaboration between LDH offices. These interviews with stakeholders across LDH will inform recommended structures and/or operating procedures to support ongoing collaboration, engagement, and decision-making regarding LDH services for people who use drugs (PWUD). Findings will be disseminated in winter 2021.

Key informant interviews will be drawn from stakeholders working within:

	REPRESENTATIVE	EMAIL	ALSO REPRESENTING
1. OPH Leadership	Kim Hood	Kimberly.Hood@la.gov	
2. OBH Leadership	Dr. Janice Williams	Janice.L.Williams@la.gov	
3. OPH Med Director	Dr. Joe Kanter	Joseph.Kanter@la.gov	BRCO, State Med.
4. OBH Med Director	Dr. James Hussey	James.Hussey@la.gov	
5. Medicaid CMO	Dr. Marcus Bachhuber	Marcus.Bachhuber@la.gov	
6. Legislative/Policy	Melissa Mendoza	Melissa.Mendoza@la.gov	
7. Legislative/Policy	Catherine Peay	Catherine.Peay@la.gov	Louisiana Block Grant State Planner and cochair of HOPE
8. SHHP Leadership	Anthony James	Anthony.James@la.gov	Ryan White Part B
9. OBH Director of Prevention	Dr. Leslie Broughman-Freeman	Leslie.BroughamFreeman @la.gov	Naloxone Distribution
10. OPH Bureau of Community Preparedness	Dr. Sundee Winder	Sundee.Winder@la.gov	OPOCs, OD2A
11. OPH Bureau of Health Informatics	Lee Mendoza	Lee.Mendoza@la.gov	LODSS
12. OBH LaSOR	Melinda Robinson	Melinda.Robinson@la.gov	
13. Governor's Office of Drug Policy	Kristy Miller	Kristy.Miller@la.gov	
14. Office of Adult Services	Michelle Brown	Michelle.Brown@la.gov	
15. State Opioid Treatment Authority	Traci Perry	Traci.Perry@la.gov	
16. OBH PATH Program	Jacqueline Porter	Jacqueline.Porter@la.gov	

Appendix B
Discussion Guide

Strengthening Systems of Care
Discussion Guide
Internal Staff

Louisiana Department of Health (LDH)
Office of Public Health and Office of Behavioral Health

Goal

Understand staff priorities, generate ideas, and secure leadership buy-in and support to inform establishment of a viable LDH Substance Use and Infectious Disease Steering Committee

Objectives

1. Identify how Louisiana Department of Health (LDH) core team members and other internal colleagues/leadership are thinking about a new structure that will assist with integrated programming for people who use drugs and are at-risk or infected with HIV/HCV.
2. Learn more about current management structures and leadership approaches that support collaboration across work units (including potential stakeholder engagement)
3. Engage core team members, other staff, and leaders with decision-making authority on the structure and mandate of a new Steering Committee and strategies for increased coordination within LDH

Introduction

Thank you for agreeing to speak with us today. The purpose of this interview is to hear your thoughts about current planning, programming, and coordination efforts by the state of Louisiana to address the needs of people who use drugs and the impact of related epidemics (HIV; HCV) on such vulnerable populations. Your participation is voluntary, and you do not need to answer any question if you do not want to do so. JSI is conducting about 15 of these interviews and the information gleaned from them will be used to develop recommendations for the structure, support, and potential activities/responsibilities of a LDH Substance Use and Infectious Disease Committee.

We are providing these services at no cost to the state of Louisiana through the HRSA/HAB SPNS-funded initiative Strengthening Systems of Care for People with HIV and Opioid Use Disorder initiative run by JSI, which aims to enhance system-level coordination and networks of care among Ryan White HIV/AIDS Program (RWHAP) recipients and other state and local entities. The purpose of the initiative is to ensure that people with HIV and OUD have access to care, treatment, and recovery services that are coordinated, client-centered, and culturally responsive.

I am Steven Young, an expert consultant, and will be leading the interview today. _________ is a JSI staff member joining me to help with notes. Our conversation today will be confidential. Whatever you share with us today will not be associated with you once our time together is complete. However, we would like to

record the call for internal JSI use only – so our team can review later if needed to clarify the notes. We expect the interview to take between 30 and 60 minutes.

Do you have any questions about this interview? If you are okay with us recording the call, we will ask ______ to start the recording and after she does this, can you say "It is okay to record this call"

Discussion questions for Key informant Interviews

Section 1: Agency Overview

1. To start, please identify your organization/office and tell me about your role(s) as it relates to reaching and serving the priority population of focus (persons who use drugs and those at-risk for or HIV/HCV-infected). If within LDH, please describe where your office/unit resides organizationally.
2. How do you currently see programs and staff collaborate and communicate across HIV, HCV, and behavioral health/substance use services?
3. What do you see as the main gaps that could be addressed by a new LDH Substance Use and infectious Disease Steering Committee?

Section 2: Leadership Commitment and Key Staff

1. What do the terms "integration" and "collaboration" mean to you? To your organization (office, program)?
2. Do you know of - or have you participated in - successful steering committees or similar structures for other programs that have successfully addressed cross-cutting health issues?

Section 3: Planning

1. What types of planning activities and responses to funding opportunities related to HIV, HCV, and/or substance use/OUD initiatives are you involved in?
2. Are there existing plans for HIV, HCV and OUD that could be reviewed and utilized to help inform any priorities and activities that might come out of a new LDH Substance Use and infectious Disease Steering Committee?
3. Is there data available that justifies the potential work of such a Steering Committee, and which could be used to measure progress over time? If there are individual sources of data, what mechanisms, if any, provide for data sharing?
4. To what extent do external stakeholders, including people with HIV, HCV infection or active substance use, have an opportunity to provide input into the work of your programs and that of a potential new Steering committee? Is such engagement valued by the LDH and what methods are used?

Section 4: Structure

1. Do you have any thoughts or recommendations about how/where a new LDH Substance Use and infectious Disease Steering Committee would be situated within the organizational structure of the LDH?
2. Do you have any specific recommendations for how the bylaws, policies and procedures should reference certain activities and/or processes? Would such documents be sufficient to sustain the existence of the Steering Committee long-term?

Section 5: Activities/Roles/Responsibilities

1. What do you think are the ideal responsibilities of this new Substance Use and Infectious Disease Steering Committee? (Probe the interviewee for high-level items [strategic planning; collaboration; policy directives; ideas for programming], as well as more specific ideas [internal communications; stakeholder engagement; cross-training and data sharing; joint responses to funding opportunities; implementing integrated service models and braided funding], etc.)

Section 6: What would an integrated care model look like?

1. In your own words, what do you envision an integrated care model would look like out in the field at the community level?
2. Do you think a new LDH Substance Use and infectious Disease Steering Committee would help foster such a model?

Section 7: Main challenges/gaps

1. What do you perceive to be the main challenges that will be faced by a new LDH Substance Use and Infectious Disease Steering Committee in integrated programming for people who use drugs and are at-risk for or who have HIV or HCV?

Section 8: Solutions/opportunities

1. What solutions and opportunities exist to address the challenges and gaps mentioned previously?
2. Please complete this sentence: With the creation of a new LDH Substance Use and Infectious Disease Steering Committee, this is what I would like to see happen: ____

Section 9: Additional thoughts/questions

1. While both demanding and stressful, how has COVID-19 allowed you and other members of the LDH to think of public health planning and response differently? Have any lessons been learned from this that can be applied to help collaborate across units and departments, agencies, jurisdictions, and with funded entities?

2. Is there anything not covered by our interview questions that you would like to share with us today?

Thank you for helping us today. We may be back in touch with you as we compile the information from these interviews.