Molly:

All right. Good afternoon, everyone. I know it's top of hour, but we have a full agenda today. So I'm going to go ahead and get started. Good afternoon. And thank you for joining today's webinar, situational analysis, pulling it all together. This is the third presentation in our series of webinars in pure learning sessions that are walking you through the new integrated planning guidance section by section, and helping to prepare your jurisdictions to develop your new integrated plan for years 2022 through 2026. Since I have begun in 2016, we have supported HRSA HAB, Ryan White Parts A and B recipients, CDC DHAP funded health department recipients, and the respective planning bodies.

Molly:

We've conducted national and individualized training and technical assistance. And we facilitate peer to peer learning. And we focus on all stages of integrated planning, including development, implementation, and monitoring of integrated HIV prevention and care plans. As I mentioned earlier, today is the third installment in our learning series. In this series of webinars in peer learning sessions is intended to review and discuss the guidance section by section, highlight jurisdiction efforts, address emerging and ongoing questions and facilitate peer engagement and learning, especially through the peer learning sessions, during which participants have the opportunity to further connect, share, and discuss challenges and strategies. You can find more information about the upcoming events, including next week's peer learning session on our website, targethiv.org/ihap.

Molly:

By the end of today's presentation, participants will be able to describe what this situational analysis section is intended to capture, identify at least two strategies to successfully complete the situational analysis section, describe approaches to leveraging the situational analysis submitted as part of the EHE plan and describe the difference between the situational analysis and the epidemiologic snapshot. Today, we're going to begin with an overview of section four of the guidance, then compare situational analysis sections for the integrated and EHE plans. Then we'll have a presentation from New York and then wrap up with a Q and A, and a quick few announcements from the IHAP TAC.

Molly:

Of course, throughout today's webinar, please use the Q and a function in Zoom located along the bottom of your screen and shown here on the slide to ask any questions that you might have. So we are going to do three quick polls here. So first one asking, were you involved in the calendar year 2017 through 2021 integrated planning process? So were you involved in the development of the last integrated plan? So we will give folks a few minutes, or a few moments. Here we go.

Molly:

All right. So I think we can close the poll. Yeah, so only about 30% of folks were involved in the development last time. So we have a lot of new folks on this call, which is great. Let's go to the next poll. Let's see here. For those working in EHE jurisdictions, did you participate in the development of the situational analysis section for the EHE plan? And you can also indicate if you were not in an EHE jurisdiction. So we'll give a few more moments. All right. We can go ahead and close it.

Molly:

So it's like about half, 54% of you working in EHE jurisdictions were not involved or did not participate in the development of the situational analysis and about 30% of you are not in an EHE jurisdiction. Okay. And then the last poll should we have again, for those of you in an EHE jurisdiction, are you using the situational analysis from your plan to help meet the integrated plan requirement? And while folks are answering, I just want to note that this webinar is not intended for folks only in EHE jurisdictions. These questions are really giving us a sense of who is on the call. And we acknowledge that again, a lot of you, this will be your first opportunity engaging with a situational analysis. And so this is a great opportunity for us to learn from those who have done it with EHE and apply lessons learned for the integrated plan.

Molly:

Okay. So let's go ahead and close that poll. Great. So it looks like again, about 33% are not in an EHE jurisdiction. And about a quarter of you are planning to use the situational analysis from your EHE plan to meet the requirement, but still have to update or modify them. And then another quarter view are still figuring out what your plan is. So this is all very helpful information and good for us to know while we work through today's content. So I'm just going to provide a few quick slides and some background information, then hand it off to our presenters, but here in the slide, you'll see... And it's something we say at the top of every webinar that we facilitate, we like to just reiterate that integrated planning is an ongoing cycle. And while everyone is likely very focused currently on stages one and two, these are not necessarily independent of the other stages.

Molly:

And so to learn more about these stages and how they all play together in the process, I really strongly encourage folks, and especially those who are new to this process and who are new to integrated planning to check out the IHAP TAC self-paced online course. It's was just chatted to you all in the chat box. It's called an introduction to integrated HIV prevention and care planning. And it's a really great way to get your feet in this planning process and understand how you fit into the work that your jurisdiction is doing. So to date, we have covered the first three sections of the integrated planning guidance. And today, again, we're focusing on section four, the situational analysis. So before moving forward, we did just want to take a few minutes and reflect on where we've been and highlight some key things that have emerged during the first half of the series.

Molly:

So really a particular importance has been the ongoing conversation around using NHAS goals or EHE strategies as the organizing feature of the new integrated plan goals and objectives. So the new integrated planning guidance does provide a template and it's strongly recommended that people use it, but it's not a requirement to use that template. The template organizes the section by four focus areas. So diagnose, treat, prevent and respond, which mirrors the way that the EHE strategies are set up. And this is a change from the last integrated planning guidance, which encouraged jurisdictions to align the goals and objectives with the NHAS goals. And so we know that this has resulted in a bit of confusion, but the bottom line is that jurisdictions are required to develop an integrated plan that advances the goals of NHAS and because the four EHE strategies are aligned with, in complementary to the NHAS goals, that can be achieved using the template provided in the integrated planning guided.

Molly:

So that's a question topic that's come up throughout this series and we continue to pay attention to that and provide clarification when able. In addition to working through that, we've featured speakers who have discussed collaboration and coordination efforts with other jurisdictions. We've touched on approaches for implementing asendemic approach to planning. And we began thinking through the monitoring and evaluation component that is required once plans are submitted. So just in recapping this, we understand that these are not issues or questions that have an easy answer. And we know everyone's working through how to respond to the guidance in a way that best reflects the needs and articulates the direction that your jurisdiction is wanting to go. And so we hope that this series has been helpful and continues to be helpful for you all. And then one last thing, before we kick it over to the presenters, we did want to respond to a few questions that we've received about the epi snapshot.

Molly:

So the epi snapshot on the next is detailed in a subsection of section three of the guidance, which is the contributing data sets and assessments. And the epi snapshot is similar to the situational analysis in that it provides summary information and both the epi snapshot and the situational analysis are foundational pieces upon which then you'll build the goals and objectives for the integrated plan. So for those of you who were involved in the development of the last integrated plan, the snapshot's similar to the epi profile that was required, but the snapshot is only a summary of the most current profile.

Molly:

If you're looking for additional resources, we'd point you in the direction of the CDC, EHE program guidance 19-1906, which speaks about the epi profile, being a snapshot and provides good guidance as to how the snapshot and the situational analysis work together. We would also point to you to appendix four in the actual integrated plan guidance, which includes a long list of data resources that you should consider referencing when creating a snapshot. And I will also note that CDC and HRSA have indicated that they've jointly updated the epi profile guidance and will be releasing it soon.

Molly:

And the reason again, that we are raising this today is that the epi snapshot is used for both integrated and EHE plans, and along with community engagement and the situational analysis pieces, all of those really set up jurisdictions to begin developing the goals and objectives for the integrated plan. So I know that this was really high level and quick overview of the snapshot, but we're going to continue to be touching on that piece of the planning puzzle throughout our learning series. And again, encourage you all to attend the peer learning session next week as well. So without further ado, I will introduce our speaker. So first we have Krupa Mehta from NASTAD. She's a manager on the prevention team at NASTAD. And we have Graham Harriman who is a long term survivor of HIV and the director of the HIV Health and Human Services Planning Council of New York at the New York City Department of Health and Mental Hygiene. I will hand it over Krupa.

Krupa Mehta:

Thank you so much, Molly. Can you all hear me?

Molly:

Yes, we can.

Gretchen:

Yes.

Krupa Mehta:

Okay, great. Thank you so much. Good afternoon, everybody. My name is Krupa Mehta. As Molly said, I'm a manager on the prevention team at NASTAD. Thank you to JSI for inviting NASTAD to be a part of this webinar. In terms of ending the HIV epidemic work, I work on our EHE portfolio, which provides support and technical assistance to EHE Phase I jurisdictions. We do this through the planning and implementation phases through different activities, including webinars and resources, peer to peer learning opportunities, including our learning collaboratives, as well as direct technical assistance to the EHE jurisdictions. Next slide. A little bit about NASTAD, we are a nonprofit nonpartisan association that represents public health officials who administer HIV and hepatitis programs in the US. We are in all 50 states, as well as the District of Columbia, Puerto Rico, the US Virgin Islands, the US Pacific Island jurisdictions as well as seven local jurisdictions that receive direct CDC funding. And we do this through interpreting and influencing policies, conducting trainings, offering technical assistance and providing advocacy mobilization for health departments. Next slide.

Krupa Mehta:

Our mission is to advance the health and dignity of people living with HIV and AIDS and impacted by HIV and AIDS, viral hepatitis, and the intersecting epidemics by strengthening governmental public health and leveraging community partnerships. And our vision is a world committed to ending HIV/AIDS, viral hepatitis, and the intersecting epidemics. Next slide. In terms of integrated planning, technical assistance, JSI is the lead technical assistance provider through the IHAP TAC, however NASTAD is also available to provide technical assistance to Phase I jurisdictions. Next slide. So what is the situational analysis and what is its purpose? The planning guidance checklist lays out the different elements that are part of the situational analysis and provides requirements and details as to what should be included in the submission. The purpose of the situational analysis is to provide a snapshot of strengths, challenges, and identify needs of HIV prevention and care activities.

Krupa Mehta:

It also is to synthesize information from the two previous sections of the integrated plan guidance section two, which focuses on community engagement and planning process, and section three, which focuses on contributing data sets and assessments. Next slide. So some things to keep in mind as you're putting together your situational analysis through the polls that were previously shared, it seems like a lot of you are new to this, or weren't a part of this previously, or for those of you who are a part of EHE, you may not be familiar with the situational analysis, but in terms of the integrated plan, you are allowed to use existing material from the EHE plan or other previous plans as long as the information that is submitted is updated to include all of the HIV prevention and care system within the jurisdiction that is going to be associated with the submission.

Krupa Mehta:

So if your EHE plan was submitted at the local level, but your integrated plan is going to be submitted at the state level to ensure that all of the activities within the state are included in that. And the situational analysis, it meets the Ryan White legislative requirement for the statewide coordinated statement of need. And also it should provide a background for the strategies in the following section, section five, which details the goals and objectives for the next five years. Next slide.

Krupa Mehta:

So here we have a breakdown of the different elements of the situational analysis. There are two sections. The first section has three parts to it. You could say first there's a overview of the strengths, challenges and identified needs for HIV prevention and care. So what is working well? What successes have you had? What have you struggled with? What's needed to fill the gaps? And to continue the successful practices and programs. And then also the social determinants of health analyzing those structural and societal factors, such as education, employment, housing, community engagement, and healthcare access to name a few that affect those health outcomes and health disparities among those populations most impacted by HIV.

Krupa Mehta:

And then the four pillars that those of you who are familiar with EHE may know, diagnosed, treat, prevent, and respond. There should be an analysis of those four pillars. The diagnosed pillar, all people with HIV should be diagnosed as early as possible, treating people with HIV quickly and effective [inaudible 00:18:35] suppression, preventing new transmissions by using proven interventions, including prep and certain service programs and responding quickly to outbreaks to get the needed treatment and prevention services to those people who need them the most.

Krupa Mehta:

And then the second section focuses on those priority populations. So based on the information that was collected through the community engagement and planning process section in section two, as well as the data sets and assessments from section three, using that information to describe how the goals and objectives will address the needs of those priority populations. Next slide. So I'm going to now talk briefly about the situational analysis section as it was laid out in EHE planning and how we can use the lessons learned from EHE for integrated planning.

Krupa Mehta:

As a national TA provider for EHE planning and implementation, we at NASTAD reviewed many EHE plans during the planning process. And so we've seen some of the feedback that jurisdictions have received through CDC. And so we're using that information here. And then also we did also host a webinar on the situational analysis back in November of 2020, prior to the EHE plans being submitted, and that webinar is available on the NASTAD website. So in terms of the purpose of the situational analysis, it's similar to as it is for integrated planning, which is to better understand the context of HIV prevention and care for the jurisdiction that is submitting the plan. And then the program guidance that was provided shares the different elements or components that are part of the situational analysis. Next slide.

Krupa Mehta:

So just some of the key components of the situational analysis for EHE identifying those strengths, challenges, gaps, opportunities, and barriers, similar to integrated planning. Again, synthesizing that local epidata and community engagement efforts, the situational analysis for EHE also included a needs assessment. And then it should be informed by and include feedback from federal state and local partners, as well as previous plans, such as Fast Track Cities or Getting to Zero. It should include the social determinants of health. It also included engaging new voices and new partners. That was a big component of EHE is ensuring that those folks who are sometimes left off the table are [inaudible 00:21:37] to the table. And again, organized by the four pillars. And for EHE there was a page limit,

whereas an integrated planning there is not a page limit. And we'll talk a little bit more about the different comparisons and similarities on the next slide.

Krupa Mehta:

So here you can see the EHE plan and the integrated plan lead side by side. So both should have strengths and challenges included in them, as far as the needs assessment for the EHE plan, the needs assessment was a part of the situational analysis. Whereas with the integrated plan, this should be part of section three, the previous section. Again, the four pillars are included as well as the social determinants of health. And then for priority populations, this was not a specific subsection for EHE but for integrated planning. It is a separate section within the situational analysis.

Krupa Mehta:

New voices and new partners, these are both included for both EHE and integrated planning and then synthesis of data and community engagement efforts as well. And then as far as the page limit, there is no page limit for integrated planning as there was for the EHE plans. A few things to just keep in mind, what we learned through our experience with EHE submission is that it's really important to use the checklist that's provided and make sure to include all of the elements. So definitely use utilize the checklist. And I know IHAP TAC has created a fillable checklist through tool can use, which is great. And then as far as like formatting and length, this is not really a priority as far as the things that are important. So there were a lot of jurisdictions that were concerned about how things were laid out.

Krupa Mehta:

And if you go back and refer to the webinar that we did in 2020, you'll see different examples of different submissions that are perfectly acceptable as long as that information that is necessary is included. And then just to keep in mind again, to make sure that prevention and care activities are both included, CDC and HRSA are very much promoting the status neutral approach to things. And so thinking through all of the things that you are submitting for whether somebody is living with HIV or vulnerable to HIV. And then again, making sure that the information that you are submitting is up-to-date and including the jurisdictions that are part of the submission. Next slide. I think that is all I have. So thank you all very much. I will do my best at the end when we have Q and A to answer any questions you all have. I'm going now hand it off to Graham for the next presentation.

Graham Harriman:

I appreciate it. I was just looking at the page limit of 10 for our EHE situational analysis and realizing we went way over that page limit. And we are at 54 for our EHE situational analysis. So it became difficult to put all that inform in 10 pages for New York, but New York is sometimes, we like to think we're a little special. So I'll just hold on for a moment for the slides.

Molly:

Yes, give me one second. I'm going to share my slide. I believe my colleague internet went out. Give me one second.

Graham Harriman:

Okay. Thanks.

Molly:

All right.

Graham Harriman:

Slide 28.

Molly:

Slide 20.

Gretchen:

28.

Graham Harriman:

28.

Molly:

Great. Okay.

Graham Harriman:

There you are. Great. So just to confuse people, I work for the New York City Department of Health and Mental Hygiene, but I'm going to start by talking about the New York State integrated plan because like Krupa was saying the states can submit the plan on behalf of all the jurisdictions and that's what we've done. That's what we did for the previous integrated plan. And so that's what we are plan planning to do again for this year. So I'm going to just give a little bit of that background and talk about the New York State plan and the epidemic, and then go into our EHE plan touch on the epi profile and the situational analysis and how we've used that. And then talk a little bit about the gaps in the plan and how we're going to address those, and then go through the timeline in our process. Next slide. I think they should be in full screen now. Atleast, they are for me. Gone for a moment.

Molly:

Can someone else... I'm sorry, everyone.

Graham Harriman:

That's right. So we've begun planning for the New York State HIV integrated prevention and care plan. And we began doing that by having what we're calling the New York State HIV planning group coordinating committee. So that includes all the jurisdictions in New York State, where we're talking about, what do we need to put together for our New York State HIV integrated plan? So the planning council is there, the HIV planning group, both part of New York City and then Nassau-Suffolk, and then larger planning groups at the state level as well. Next slide.

Graham Harriman:

So just to refresh people's memory in regards to the integrated prevention and care plan, it's our second five year plan that we're working on here. It builds on the first iteration of the integrated plan guidance, and they been a bit more flexible than the first one where we're able to use work that we've already

done and have done over the last several years to use as the basis for the plan. But they're expecting us to have goals and objectives and add or advise services to address local health inequities that may remain. And so it is a partnership between CDC and HRSA, and they do recognize that we've had all sorts of initiatives between the EHE funding, fast track cities, getting to zero, and then of course are the molecular outbreak detection and response plans. So a lot of work has been done across the country in different jurisdictions, and they are nicely and happily recognizing that work.

Graham Harriman:

And this is using our EHE situational analysis is part of that. So next slide. And this just language from the integrated plan guidance that we shouldn't be developing a new products, and you can use things that are current and you can update products that you have. And so that it's fair game to use these documents. So that makes it easier for all of us. So just a little bit about what we have in New York State, we had a planned to end the epidemic that the process began in June 2014, and there were three points highlighted in the plan, which is identify people with HIV who remain undiagnosed and get them linked to care. Link and retain persons diagnosed with HIV and then increased access to prep for persons who were HIV negative. Next slide.

Graham Harriman:

And that process resulted in the ETE blueprint for New York State, which called for the creation of an ETE task force, which was charged with strategies to achieve the goals outlined in that three point plan. And so if you follow that link, there's a whole list of recommendations that are contained in this blueprint that the state has been following up on. We've all been working on since 2015. And then, while the city was working on our EHE plan, state also did an ETE beyond 2020 plan, where they went around to all jurisdictions in the state and gathered additional information in regards to how were we able to do with the original ETE plan, and what do we need to do to continue the momentum and continue to address the needs for people who are undiagnosed and need to be linked to care, supporting people with HIV, as well as helping people to stay HIV negative. Next slide.

Graham Harriman:

So in the ETE beyond 2020 process, they identify the need to address health disparities, to really focus on health equity, as well as incorporate to informed care. And then of course, as we all have been managing over the last several years address, COVID-19 and the impact of COVID-19 on our work. So back there, great. So each jurisdiction is expected to have plans that address four goals to prevent new infections, improve HIV related health outcomes for people with HIV, reduce disparities and health inequities, and then achieve integrated coordinated efforts that address the HIV epidemic among all partners and stakeholders. Next slide.

Graham Harriman:

So then also addressing the COVID-19 impact because it has been a huge issue in thinking about how do we address isolation, the challenges with routine HIV, hepatitis C, and STI testing, addressing misinformation and the politicization of mask wearing, the mistrust and the fear of ineffective treatments, the mental health issues that have been compounded by COVID-19 issues of job and employment and income, issues around technology and proficiency and capability to use technologies in specific believe for telehealth, issues of medication adherence and lack of access to equitable care services, which echoes the inequities in our culture in terms of the poor health outcomes. And the inequities in mortality for persons of color, black and Latino folks in New York State. And really calling

that out because that's a reflection of the larger issues of inequity and structural racism in our culture. Next slide.

Graham Harriman:

So New York City's plan ending the HIV epidemic plan feeds into the integrated plan and the ending the HIV epidemic plan for New York State. And I have to just say, my job is to oversee the planning council and describing all of the levels of the different iterations of different plans and aspects of plans is a big challenge, when it comes to community planning. So we've been trying to be very mindful about where we use EHE, which is reflective of the federal plan and the city's plan in response to the federal plan.

Graham Harriman:

And then we ETE for the state's plan and the epidemic. So ho hopefully, that's helpful to you all. So in the New York City, EHE epi profile, we included data on diagnoses included, linkaged care, viral load suppression, mortality among people with HIV STI, and then also comparison comparisons by geography of the ending the HIV epidemic counties, Bronx, Brooklyn, Manhattan, and Queens, and then also comparing different priority populations. The link to the epi profile is there on the bottom of the slide, if you need to use it, just look at it. And then we also did a situational analysis and preparation for the EHE plan.

Graham Harriman:

And the data in the situational analysis supported our community presentation so that we could receive input on the draft plan. It helped to form key activities in the plan, and it identified an initial list of priority populations. Aspects included in the situational analysis, just to sort of bring it to light a little bit included issues around housing, immigration status, food insecurity, poverty, incarceration, mental health, substance use, intimate partner violence, sex exchange, sex work, health insurance, workforce, and the state of the workforce in terms of addressing HIV prevention and care.

Graham Harriman:

And then like Krupa had talked about needing to really think about our partners in addressing our work. So including viral hepatitis programs, STI programs, but also education department for the aging because one of their priority populations is people over 50 once again, addressing workforce, but also thinking about broader community planning organizations. We have a long term survivor wellness coalition for instance, in roping those folks in and ensuring that they're up to date working with the sexual health advisory group, which advises the city in ensuring that they're brought into the plan and are engaged and able to give input.

Graham Harriman:

So thinking broadly about those partners was important. And it was interesting to spend time because of the requirements of the situational analysis and have all of us here in the bureau, think about all of our partners. And it became a list of over a hundred organizations that we work with beyond the contractors that we have. So really forcing us to think broadly about who our partners are and engage them in this plan and the epidemic. Next slide.

Graham Harriman:

So to guide the plan, we also had held a nearly year long community planning process, which included nine community listening sessions with 308 participants. And then we also had an online survey and all of this was in the midst of COVID. So we didn't have quite the number of participants that we expected, and that's why we added the online survey. And then of course, the planning council and the HPG provided feedback on drafts of the plan, and then both the planning bodies voted for concurrence. And this aspect is important when you're thinking of the integrated plan to just sort of that these planning bodies already have that foundation of working with the EHE plan, which they approved so that they're familiar with it. And they're familiar with the aspects of it and are able to provide input in terms of how can we update those plans. And so it's not like we're starting from square one, so that's really helpful. Next slide.

Graham Harriman:

And then in our New York State integrated plan, we are very aware that we have gaps in our EHE plan. And that includes the fact that two areas of our eligible metropolitan area for the Ryan White grant were not included in the federal EHE initiative. So Staten Island, which is one of our boroughs is not included. And then we have to the tri-county area, just north of the city, which is Putnam, Rockland and Westchester counties. So we need to include data on those counties in our updated integrated plan. The nice thing was that the state did in their beyond 2020 work, did do listening sessions in those areas. So we can use some of that data and then bring it back to planning bodies to get some additional information. And then once again, the epidata will need to be updated for these areas, but it also needs to be updated just in terms of the data.

Graham Harriman:

Because I believe that the EHE plan has 2018 data in it. So we'll need more recent data included. Next slide. So our timeline here in New York is to have those bimonthly coordinating group planning meetings with which we're calling the lack of a better word, super committee. Its official name is the New York State HIV planning body coordinating committee meeting. But super committee is a little faster to say. And so there's been a big call for documents and that call for documents has gone to the city health departments and the county health departments. But it's also gone to Ryan White Part A, B, C contractors and programs, as well as those who are funded directly funded by the CDC.

Graham Harriman:

So all those documents will be put together by the state and then they'll begin writing it. And so they've already begun planning meetings earlier this week. They met with the HIV planning group on Thursday. They're going to meet with the planning council and the state and myself will be presenting on introducing the integrated plan to folks and also using actually some of these slides to help people understand that we've already done a lot of the foundational work. And then there will be community convenings likely in August, September, and then we'll have drafts for review and input that will be out there for comment. Next slide.

Graham Harriman:

And I think I said a lot of this, I just went ahead of myself. So we'll be assessing for missing information after we compile all those documents and write the narrative and then we'll begin to go back to the advisory groups for feedback, have a public comment period, and then develop those letters of concurrence, which we expect to have done in October. And then we'll once again, post that version up for public posting. And that's all I have. Happy to take questions. I saw some comments in the chat, but I

did not look at them. I'll look at them now. Yeah. And Gretchen was noting that the integrated guide for developing epi profiles did come out yesterday. So that link is in your chat. So that's going to be helpful for you to look at. And Kevin said labeling the various plans has a big challenge. Absolutely.

Molly:

Wonderful. Thank you so much, Graham and Krupa. We're going to move into our Q and A right now. Julie, I am happy to share my screen if that's easier. Before we do get into that though, I did just want to ask that if you have to drop off before the webinar ends today, if you could fill out the evaluation form that my colleague Chavy is going to be sending around. This is really helpful for us in understanding how these webinars and peer learning sessions are being received and really helps us understand what other needs and feedback you all have that we can address through future presentations. So it would be wonderful if you could take the time to fill that out. So give me one second here to just take a look at the questions that we received today.

Molly:

Okay. We're just sort of getting situated these different questions. And I also did want to also just point out my colleague Gretchen chatted in the chat, but we received word that yesterday HRSA and CDC released the updated integrated guidance for developing epidemiologic profiles, HIV prevention, and Ryan white HIV/AIDS program planning. So that's the updated epi profile guidance that I mentioned earlier was forthcoming. Look at that. It's ready for you to access again, Gretchen chatted in the link to that PDF, but it's been updated to reflect new data sources and new core questions that align with the NHAS and also EHE, so please do check that out. I'm sure everyone is scrambling to go download that now and take a look, which is exciting. Thank you, Graham and Gretchen for giving that out there for us. So question here for Graham, if you don't mind. So the question is, who does the actual writing of the narrative section? Is it the same writer for the other sections as well? It's a wonderful question.

Graham Harriman:

So for the EHE plan, the situational analysis, as well as the plan, we had a contracted writer who worked with all of us, and then there was a team of us that reviewed every draft. And we probably had six drafts of that plan. The state's integrated plan, I believe that the state is going to get a contracted person to write the plan. It has just seemed to be easier for all of us with our other full-time jobs to have someone who just that's all they do is focus on biting the plan. And that seems to have worked well for us.

Molly:

Great. And Graham, if you wanted to stay on, we have a question here. What advice would you give jurisdictions that have not developed a situational analysis before? So earlier we asked those poll questions, and there are both a lot of people who are new to integrated planning and also new to doing the development, a situational analysis. So what sort of feedback or hot tips might you provide?

Graham Harriman:

Well, we started our process by just doing a big call for documents. So for the EHE situational analysis, we had all the directors get together and ask people in their groups, what sort of data they had on hand? So what sort of focus groups have been done? What surveys have been done? Epidata, of course, but then there have also been like specific efforts on looking at the issues of people with serious mental illness, specific efforts on addressing the needs of people over 50, specific efforts looking at the needs of

young MSM of color black and Latino MSM and ensuring that all of that background works, which had happened over the last several years was included.

Graham Harriman:

So that we weren't starting from scratch, but we are actually building on the work that we already had. And I think that all of that information served to create the situational analysis and it worked out pretty well. There were a couple of gaps that we had to address, but we did that by either doing the lit search, if there was a gap that we couldn't find locally and that seemed to work out pretty well.

Molly:

Great. Thank you so much. Next I'm going to hand it to my colleague, Gretchen, who's going to talk a little bit more about the NHAS and EHE framework. So the question is, this person was told that they can use the NHAS rather than the EHE framework, and that is what the community in their jurisdiction would like. However, it is clear from the guidance that they need to incorporate the EHE focus areas, any guidance, or insights into that dilemma.

Gretchen:

Yeah. Thank you for the question. And as Molly noted, this has definitely been a theme throughout the series. So it is absolutely correct that there is not a required format. So particularly if the community really wants to structure the plan along using the NHAS goals as the organizing structure for the plan, then I think that is a relatively strong rationale for doing that, but you are absolutely correct that in both the goals and objectives section, as well as throughout other sections of the integrated plan guidance, information is being asked to be organized alongside the four strategies that are all often identified as the four EHE strategies diagnose, treat, prevent, and respond.

Gretchen:

So in terms of guidance and a recommendation, what I would encourage you to do is for however you organize goals and objectives underneath the NHAS goals as that organizing principle, how can you tag a particular goal or objective and note that they can be used interchangeably as being associated with one or more of the strategies, so that you can show CDC and HRSA that you have at least three goals for each one of those strategies. So again, it's essentially a recommendation to think about tagging your goals and objectives with reference to one of the four strategies, if you are following the NHAS goals as the organizing principle for your integrated plan. There may be other approaches that jurisdictions are considering. I would welcome you to others to comment in the chat. If you are taking a different approach into the person who answer or ask that question would be interested to know if that seems feasible and reasonable as well within the context of your integrated plan development.

Molly:

I'm going to go ahead and Gretchen, if you want to, I'm going to put this question out there. Anyone feel free to jump in. So asking for clarification or confirmation that the integrated plan requires an epi snapshot as opposed to a full epi profile. Can we confirm? And also a little more information, if possible, about the guidance for the snapshot, will that be released in the next couple of months? What's the status on that?

Gretchen:

Yep. I can touch on that. So the epi snapshot is in fact, a snapshot. It is not the entirety of the epi profile, but we will also make it available through all other communication that we do about this webinar. In the chat, you will see a link to the updated guidance from CDC and HRSA creating the epi profile. So that's hot off the press. We didn't even have it before we began this webinar, but thanks to those who pointed it out, it does live, it is out there, but I will say I haven't had time to review it.

Gretchen:

But yes, the snapshot is just that it is a briefer version of the epi profile. Within the integrated plan guidance checklist, there is requirement detail about what should be included in the epidemiologic snapshot. And in an earlier slide, my colleague Molly also pointed to the 19-1906 guidance from CDC for the EHE plan development. And the reason for pointing to that guidance it's really to serve as an additional resource for how an epi snapshot is described as the EHE plan required an epi snapshot, just as the integrated plan required an epi snapshot.

Molly:

Gretchen, a question just came in. Is the epi profile due at the same time as the rest of the integrated plan?

Gretchen:

Okay. I don't want to misspeak on this. And so I'm not going to speak on... I don't want to misspeak on this. I want to pull up the guidance and to be clear about that, but my belief is that there are different due dates and requirements for when the epi profile is submitted, but please don't even quote me on that. Let me just do some digging and see if I can do it at the next few moments. But also welcome anyone else to join in the conversation or save me in the chat if you know the answer off the top of your heads.

Molly:

All right. I think we're going to go ahead. So yes, please do. We're going to wrap up a few announcements and housekeeping. If you do have it off the top of your head or find it, or have any more questions, please continue to chat them in. But if we go to the next slide, we just want to plug the accompanying peer learning session, which is taking place next week. I believe the 30th, yes is a Wednesday from 1:00 to 2:00. And again, the peer learning sessions are a time for folks to come and collaborate and communicate. There's no structured presentation. Really, it's an opportunity for you all to ask questions and bounce ideas off one another. And then actually, you don't need to have attended this webinar to attend next week's peer learning session.

Molly:

And then the next webinar, the date is still being hammered out, but the content is going to focus on section five of the guidance. So that's goals, objectives, and strategies. It will be likely in April at some time, but we will, of course certainly communicate that as soon as the details for that are confirmed. We also are excited to announce that the HIV prevention care and treatment resource inventory compiler is now live and available on our website. So this was the tool that was featured on last month's webinar. And again, it has the capability to capture information needed for the resource inventory section of the integrated plan. It can create a table and PDF that you can submit as a part of your integrated plan, and it can analyze data with a number of pre-programmed options. And so the compiler link was just sent out in the chat and we are really excited for you all to use that.

Molly:

And as always the IHAP TAC team is here to help. Please, don't hesitate to reach out to us with any questions ihaptac@jsi.com. You can visit us on our website at targethiv.org/ihap, where you can join our mailing list and find our introductory online course on prevention and care planning. And again, you can reach out for tailored technical assistance again, at our email, ihaptac@jsi.com. So before we wrap up again, we ask that you please fill out the evaluation form that's going to pop up once this webinar is ended. And thank you so much for our wonderful presenters. We appreciate you both joining us today, and we will see everyone hopefully next week. Thank you so much and have a great afternoon.