Molly Tasso: All right. I think we're going to go ahead and get started at this afternoon. Hi, everyone. Welcome, excuse me, to today's webinar, Gearing Up For Integrated Planning, Approach, Timeline, and Community Engagement. This is the inaugural presentation in our series of webinars and peer learning sessions that will walk you through the new integrated planning guidance section by section, and help prepare your jurisdiction to develop your new integrated plan for years 2022 through 2026.

The IHAPTAC began in 2016 and the project supports HRSA, HAB, RWHAP Parts A and B recipients, CDC DHP-funded health department recipients, and their respective HIV planning bodies. Conducts national and individualized training and technical assistance and facilitates peer-to-peer learning, and focuses 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 kickoff for our new learning series, which will support jurisdictions in the development of your integrated plans. The learning series consists of webinars in peer learning sessions. And the purpose of the series is to review and discuss the guidance section by section, highlight jurisdiction efforts, address emerging and ongoing questions, and facilitate peer engagement and learning specifically through the peer learning sessions, during which participants will have the opportunity to further connect and share and discuss challenges and strategies. We understand that there is no one fits all approach to planning and the process looks different for each jurisdiction.

Our webinars and peer learning sessions take into consideration the context in which jurisdictions are planning, including rates of HIV diagnosis, geography, and whether or not the jurisdiction is engaged in phase one of the ending HIV epidemic initiative. You can find out more information about our upcoming events, including the January 31st peer learning session on our website, targethiv.org/ihap.

Now I am very pleased to introduce Dr. Susan Robilotto, the Director of the Division of State HIV/AIDS programs from HRSA/HAB. Dr. Robilotto?

Susan Robilotto: Thank you, Molly. Hello everyone. On behalf of the team at HRSA and CDC, I want to welcome you to the first of many webinars in this new integrated plan webinar series, which will focus on two very critical components of the integrated planning, the best approach and community engagement. This series was developed using your input and questions, and we hope that it will assist you and your respective teams in preparing for this year's integrated plan submission. We would like to also remind you that in addition to this webinar series, both HRSA and CDC will continue to provide you with technical assistance and resources to support both the development and implementation of your integrated plans.

As you conduct your planning process in your local jurisdictions, this new integrated plan should function to build on the success and momentum of the inaugural integrated planning process that was started in 2015. If you have any questions related to the integrated plan guidance, we encourage you to share those with your HRSA and/or CDC project officers, and to get clarification from them. With that, I would like to thank you for your time and attention, and I will turn it back over to the IHAP tech team to get started.

Molly Tasso: Great. Thank you so much for those remarks and for joining us this afternoon. So before we move into the formal presentation, I'm just going to provide a quick overview of the objectives for this afternoon. The objectives today, our idea is that at the end of today's webinar the participants will be able to describe at least two approaches to coordinating the integrated planning process, identify at least two strategies to engage community members across the integrated planning life cycle, including identification of new stakeholders and voices, discuss opportunities to adapt traditional engagement approaches to the current environment to ensure ongoing, meaningful stakeholder input and feedback, and better understand the connections between integrated planning and other HIV planning efforts.

So today my colleague, Gretchen Weiss is going to start us off by providing a lay of the integrated planning land and national HIV planning initiatives, then provide brief overviews of sections one and two of the integrated planning guidance. She will provide a high level introduction to HIV planning terminology, then hand it over to our jurisdictional presenters from Arizona, Iowa, and Maryland.

We will have time at the end to answer some questions and then wrap up and discuss next steps in our learning series. And in addition to today's live presentation, we've put together what we're calling the digital webinar companion guide, which provides information and resources to supplement what we cover today on the webinar. And this companion guide contains the presenter bios, the presentation slides, questions for considerations, integrated planning resources, and then information on the next steps. So the peer learning series. And we'll go ahead and chat out a link to that now as well. And then finally, throughout the webinar, of course, please use the Q and A function located at the bottom of your screen and shown here on the slide to ask any questions that you might have.

Today our content's focused on related to sections one and two of the guidance, but please do feel free to submit any questions that you might have. And while we may likely not get to all of them during today's webinar, we will work with HRSA and CDC to ensure all questions are addressed. And also questions help inform content for future sessions, so please do send in anything that you have. So with that, I'm going to hand it over to my colleague, Gretchen, who's us off with a question.

Gretchen Weiss: Thanks so much, Molly, and hello everyone. I am so glad to see such great participation in today's event. So before getting started, as many of you have already started responding to the poll, we're looking to get a sense of who is in this virtual room, who in terms of who you are in relationship to integrated planning. So please let us to know if you were involved in the previous iteration of the integrated planning process for calendar years 2017 to 2021. We've got a lot of responses still coming in. So we're going to give it just a few more moments until I start seeing this winding down.

And I think we're good. So let's go with three, two, one, and we can close the poll and let's take a look at the results together. So hopefully everyone can see these poll results, but it's a bit of mixed bag. 31% were involved previously, 66% were not, and 3% can't remember. Which can't blame you, it was many years ago. And so it's a mixed bag. And the good news is that the webinar today really is going to be relevant across the board and speak to everyone. So thank you again so much for joining. Next slide, please.

Okay, great. I'm going to spend the next 20 minutes setting the stage for our presenters from Arizona, Iowa, and Maryland, who will really bring to life what is laid out on my slides. And just as a reminder this webinar is scheduled for an hour and a half. We hope that you'll be able to stick with us through the end so you can hear all of the great recipient presentations, but if not, definitely encourage you to come back to the recording. It'll certainly be worth your while. They're really excellent.

So first I want to begin by acknowledging that integrated planning is an ongoing cycle. Right now, it can be assumed that everyone is very focused on stages one and two of the cycle, organizing and preparing for integrated planning, prioritizing activities, and actually developing the plan itself. But these stages are not necessarily independent of three, four, and five implementation, monitoring, and communication. And describing how you will undertake those future stages is part of the planning process. So wanted to contextualize us in this cycle and also make note that if you are interested in learning more about the stages of integrated planning, particularly for those of you that are new to this process, really encourage you to check out an IHAP TAC online course, that is an introduction to integrated HIV prevention and care planning. My colleague, [Shivy], will put a link to that in the chat, and it's also included in the companion guide for the webinar today. Next slide, please.

So to lay the ground for the rest of the discussion about integrated plan development, I'm going to review just a few key details. So the guidance was released in June of last year, and plans are due in December of this year, so a little bit less than a year to go. This current guidance, as we've already heard, builds off of the guidance that was released in 2015 for the 2017 to 2021 integrated plans of which roughly a third of you were involved in developing. The integrated plans meet all programmatic legislative requirements that are

associated with the CDC and HRSA funding, and plans are living documents to be reviewed and updated as needed. Next slide.

So we recognize that in many jurisdictions, I should say really all jurisdictions there are multiple HIV planning initiatives and related initiatives. And want to take a few minutes to examine the connections between integrated planning and other HIV planning. So the image on this slide is often used by CDC and HRSA to describe the relationship between the National HIV/AIDS Strategy or NHAS, the Integrated HIV Prevention and Care Plan, the EHE, or Ending the HIV Epidemic initiative, as well as other programmatic applications and submissions. So these would be the work plans for your part A and part B awards or your CDC HIV prevention funding among many others. But in many ways, this is really just the tip of the iceberg. Next slide, please.

So this table attempts to reveal more of the iceberg and even so it is not an exhaustive list of the potential plans that may influence or contribute to the integrated planning process. The table is organized by the geographic scope of the plan. So at the national level we've also added or acknowledged the STI and Viral Hepatitis Strategic Plans, which may have compliments at the jurisdictional level. And at the jurisdictional level you'll see many of the planning initiatives that are referenced in the integrated plan guidance as having the potential to be used as existing material for the integrated plan submission. Though we do acknowledge that it isn't necessarily as simple as that sounds given that the scope of these plans varies. Scope in terms of what's covered. Scope in terms of the geographic jurisdiction that it speaks to. Scope in terms of who was involved in its development.

And so given this variation, it is unlikely that any one plan will meet all of the requirements for the integrated plan submission. So even though existing materials can be used, they will likely need to be adapted, updated, modified in order to meet the integrated plan requirements. And we'll talk more about that further later on.

Oh yeah, thank you. The table also recognizes planning activities at the recipient or organizational levels such as the work plans for specific funding streams or strategic plans for an organization. And then that bottom row emphasizes that [inaudible], and really at the core of all of these planning initiatives there are some overarching principles, and we've included a few key principles here. So community engagement, but also community ownership, community leadership for this work, particularly at the jurisdictional level. Achieving health equity and reducing disparities, including by addressing racism and discrimination. Focusing on priority populations and implementing a status neutral approach. Next slide, please.

So the existence of other planning initiatives influences how a jurisdiction approaches the integrated planning process, which we'll hear more about during the recipient presentations. This slide highlights a number of other

factors that impact jurisdictional approaches to integrated planning. So there are the specific needs of the jurisdiction, the feasibility of the various approaches, and of course, there's a lot that impacts that. And we know that COVID-19 is certainly among those impacts on both the feasibility, as well as the context for planning. In terms of some of the other key factors we've already on the previous few slides talked about the EHE initiative and other planning initiatives that really influence how to go about structuring the approach to integrated planning, but a few others to highlight.

So the type of integrated plan submission based on the grantees and the jurisdictions involved at both the state and local level. And so what that speaks to is that with any state there are differences both at the state level and at the local level, local speaking to both city and county health departments in terms of who is getting funded and what the requirements are to submit an integrated plan. And there are different options for all of the state and local funded entities to come together and submit an integrated plan or to submit independently. And even when submitting independently as a state only or a local only plan communication coordination is absolutely essential, but it is important to recognize that the plans are going to look different, and that means that they're going to have different approaches.

Other factors are the extent to which the jurisdiction is taking a syndemic planning approach, the planning bodies and structures across the jurisdiction, and the overall infrastructure for planning and the expertise and experience and existing relationships in particular with community and other stakeholders involved. Next slide, please.

So as mentioned previously, community engagement and leadership are overarching principles and requirements of many planning initiatives, whether that is in regard to plans and guidance that are developed by the federal government, state and local government or coalitions and other planning groups within jurisdictions. And that's certainly evidenced by the leadership that was seen for the original Getting To Zero and Ending the HIV Epidemic plans. Community engagement is essential to meaningfully and effectively meeting the needs of priority populations and working towards reducing disparities and achieving health equity. And we are going to hear much more about this from our recipient presenters, so stay tuned for that. Next slide, please.

I'm going to transition now to speaking more specifically about the integrated plan guidance with a focus on the first two sections. Next slide.

So here we have a bird's eye view of the guidance, which includes seven sections. And then within each of these seven sections there are multiple subsections and the all important appendix one of the guidance also referred to as the checklist provides detail on the requirements for each section and subsection. So that is certainly, that checklist is something to hold very near and

dear throughout this entire process. And we'll speak more of that in the coming slides. Next slide, please.

A few important new features of the guidance to highlight here. And for those that are new to integrated planning, just want to make the note that new feature means that this is not a part of the 2015 guidance for the 2017 to 2021 plans. This is really new for this current guidance. So first as previously alluded to jurisdictions can use existing HIV plans to satisfy requirements as long as it addresses the broader needs of the geographic jurisdiction, applies to the entire CDC and HRSA HIV funding portfolio, and includes updates that describe ongoing activities. So this really speaks to what I mentioned a few slides ago about this being a great feature of the guidance really reflecting and acknowledging the time and effort that's been dedicated to other planning initiatives and the opportunity to leverage that as opposed to duplicating it through the integrated planning process.

But it is important to note that given the specific aims and requirements of each of the different planning initiatives, there is not that overlap that I touched on earlier. Just one example of this to bring it to light is that the EHE planning was often for a specific county, in some cases an entire state, but often for a specific county. And then when we think about our part A jurisdictions, well, part A jurisdictions include many counties. So an EHE plan does not fully overlay for a part A jurisdiction. And that's just one example.

So another key feature is the use of a checklist which details the requirements by section, allows jurisdictions to indicate whether new or existing material is being used. And the checklist must be included in the submission. And I see it's already been dropped in the chat. We're really excited to share a brand new IHAP TAC resource, which is a fillable checklist. This resource follows the same format as the checklist in appendix one, and can be submitted with the integrated plan. So we really hope that you find this useful. Next slide, please.

So as Molly outlined at the beginning of the webinar, our webinar and peer learning series is going to work through the guidance section by section. With this webinar being really focused on components related to the first two sections, which we're going to briefly review on this slide and then the next. And it's great to see that there's already support and thanks for the fillable checklist in the chat. Thank you for that.

So the first section is the executive summary, which like any executive summary provides an overview of and a roadmap for the rest of the document, the rest of the integrated plan submission. It serves as an introduction to the integrated plan and describes the approach to developing it. So as such, there is no existing material that can be used to meet the requirements of this section of section one, though, it should detail how existing materials are used in other sections of the submission. Next slide, please.

Section two includes eight subsections that detail the jurisdictions planning process, the planning groups and other entities involved, and how people with HIV were engaged. The section emphasizes using innovative approaches to bring new partners and voices to the planning table and does allow for the use of existing materials. And another plug, we've got a lot more on that coming from our recipient presentations. Next slide please.

So I'm going to close with three slides that speak to how to structure and organize goals and objectives, which is section five of the guidance, but really foundational to the planning process, which is why we're addressing it here in terms of gearing up for that planning process and thinking about approach. The guidance references both the national HIV/AIDS strategy or NHAS and the EHE initiative as what we're referring to as organizing principles. The inclusion of EHE as an organizing principle is of course new as the initiative was not underway when the previous guidance was-

PART 1 OF 4 ENDS [00:23:04]

Gretchen Weiss: As the initiative was not underway when the previous guidance was issued, the four strategies associated with the EHE initiative, diagnose, treat, prevent and respond are used throughout the guidance, including in the description of the requirement for the goals and objective section, as reflected in the bullets on this slide about what the checklist states. We know that this has been an area of some confusion as the guidance also notes, aligning goals and objectives with the NHAS, but hopefully over the course of the next few slides and really the session overall you'll be convinced that they aren't all that different. The CDC and HRSA have underscored that there is no required format for this section of the guidance, but they have also emphasized that following the example, goal structure in appendix two will ensure that recipients meet submission requirements.

I want to point everyone to the chat. My colleague, Shydeeh just dropped in a link to a page that if you scroll down, you'll be able to access a webinar that CDC and HRSA led on October 27th to review the guidance and touch the quorum, this issue as well. So we'll continue to talk about it here and throughout this series, but also want to make sure that everyone has that as a helpful reference. Next slide please.

So here is appendix two. This template is likely familiar to some of you as it comes from the planning guidance for the jurisdiction involved in phase one of the EHE initiative. As such it uses the EHE strategies, which can also be referred to as pillars, but it uses the EHE strategies as the organizing principle. Meaning that it is underneath those strategies that we see goals and activities. It is worthwhile to note that the word objectives does not appear in the template, though the integrated plan guidance refers to goals and objectives and instruct that there should be at least three goals and objectives for each of the four strategies. We expect that CDC and HRSA are going to be providing further

clarification on this in the format of an FAQ document, but in the meantime, jurisdiction is to determine whether or not they will follow the template outlined in appendix two. And if not, what structure will be used instead and how they will ensure it includes all of the required elements outlined in the integrated plan guidance. Next slide please.

So a final point for this, for the time being, and I mean, for the time being as just this slide, it is definitely not the final point on this. We are excited and eager and will continue to be here as a resource and support for jurisdictions as you work through your approach and how you'll be organizing your goals and objectives. You're going to hear more about that from our recipient presentations, but I just want to look here at the NHAS goals and the EHE strategies together. The NHAS goals are defined as broad aspirations that enable the plan's vision to be realized. And within the NHAS for each of the four goals, there is a set of objective underneath the goals and then strategies for how it will be accomplished. And I really encourage you to check out table three in the national HIV/AIDS strategy, which includes helpful definitions for these terms, goals, objectives, strategies.

And we've also included that information in the independent guide. Now on the right hand side, we see the EHE strategies, which are defined as focus areas for scaling up efforts to end the HIV epidemic. Under which jurisdictions have identified specific goals and activities for doing so, as we just saw in the template for that structure, that's included as part of appendix two. So the NHAS goals and the EHE strategies are closely aligned and complementary. And I will say those are not by words. They are the words of the national HIV/AIDS strategy, as well as what is reflected in the guidance. The EHE strategies really represent key areas of effort for achieving the NHAS goals. So by organizing goals and objectives for the integrated plan in the context of the four EHE strategies, it is certainly in service of the NHAS goals. The integrated plan is really a space for jurisdictions to use this structure, use these guiding strategies and national goals to pave your way, your story for how your jurisdiction aims to implement these strategies, to achieve these goals.

So with that, I am excited to turn this over to our recipient presenters, who will share how they're operationalizing all of this in their jurisdictions. The companion guys includes bios for all of the speakers. So we are going to bypass those during the webinar, and I'm going to turn it over to Deborah and Isabel in Arizona to begin who will then pass it off to Holly in Iowa and Carmi in Maryland. So thank you so much for your attention to my presentation on behalf of the I Hab tag and Julie, you can advance the slides and pass it on over to Deborah and Isabel to take it away for Arizona.

Isabel Evans: Hi, all thanks so much for having us. We're very excited to give you some information on what's going on here in Arizona. Can we get the next slide, please? Thanks so much. So just quick introductions. My name is Isabel. I use

she, her pronouns and I am with our state health department's HIV care and services team as a program coordinator. Deborah, you want to go ahead.

Deborah Reardon...: Thanks. I'm Deborah Reardon-Maynard. I also use she, her pronouns and I am with HIV prevention program at ADHS, working in the program improvement area.

Isabel Evans: Thanks. Okay. So what we're going to do today is pose a handful of questions and then answer them for you about our planning process for planning, what we very kindly like to refer to as planning to plan. Next slide. Thanks. So our first question is what's our context. I think that for us, we felt that it would be helpful for you to understand where we're coming from. So you can understand the decisions that we made about our planning process. Next slide. So our first big context is who is doing the work here in Arizona. As Deborah and I just mentioned, we're both at the state health department, ADHS. Here at the state health department we've got a bunch of teams. We've got our HIV prevention folks, Ryan White Part B and A, viral hepatitis, STD control. All these folks are involved in planning, and we are very lucky that we actually all exist within the same office, along with our surveillance for HIV and our TB folks.

So we exist within the same office. We can coordinate on projects, programs, and funding, which makes our work a lot easier. The other piece is that our county is also here in the same city, our state health department, and our Maricopa County department of public health are both located in Phoenix, which is our largest city by a long shot. And Maricopa County actually has about two thirds of the folks with HIV living in the state of Arizona. So we have sort of a very unbalanced state where the majority of our population is in one city and one county and our Ryan White folks are Phoenix EMA are part A, over at the county, cover Maricopa County and Pinal County. So a really large span of our population here in the state. We also like to point out that we've got a second Ryan White part A in our jurisdiction, our northwestern county, Mojave County is actually covered by our Las Vegas TGA up there. So we coordinate with them as well.

I think one of the things about our context that's really important is that we are an EHE phase one jurisdiction here in Maricopa County, which is where Phoenix is located. As I mentioned, we actually have a part A in this jurisdiction. And so there's a little bit of split responsibility for EHE work. Here at the state health department the HIV prevention team receives CDC funding and therefore CDC responsibility for those tasks such as writing the county EHE plan in 2019 and 2020. However, our part A in Phoenix actually receives HRSA money and therefore the HRSA responsibilities along with providing care for folks under EHE. So it means that we have to do a really good job of coordinating with our part A here at the state health depart, which houses our prevention and part B. So there's a lot of ongoing communication, making sure that our plans and work align, especially and highlighted during our EHE work of the last few years.

Next slide. Okay. So not only do we have a lot of folks involved, we also have a lot of planning groups. We have a Statewide Advisory Group, the SWAG. Which is our HIV prevention and Ryan White part B planning group. Luckily for Deborah and I, these two programs prevention and Ryan White part B did create this one unified planning group for the last integrated plan in 2016, which is very helpful for us, but we also have our Ryan White part A planning councils, both in Phoenix and Las Vegas. We've also got fast tracked cities here in Phoenix, which has their own planning group as well. About a year ago, so I'd say early 2021, maybe late 2020, our fantastic colleagues in our viral hepatitis team also started a hepatitis C statewide planning group focused on hepatitis C elimination. Our STD folks in the state health department, although they don't have a statewide planning group of their own are very involved in national groups as well. Next slide.

What does this mean for us? It means that a lot of things exist in our state and a lot of different people are in charge of a lot of different things. We've got EHE. We've got hepatitis C elimination. We've HIV integrated plan. We've got viral hepatitis plans. We've got national plans, local plans, tons of stuff going on. So when we started our integrated plan, we really wanted to make sure that we honored the work that had already been done, especially in EHE, which has just happened about a year and a half ago. And Deborah and I were leading that effort here. And we wanted to use what already existed as our foundation, instead of starting over. Another decision that was made is rolling our EHE plan into our integrated plan because Deborah and I here worked on EHE we're also working on integrated planning. As I mentioned, those are both happening at the state, even though one covers the county and one covers the state. So trying to work smarter and not harder is the motto here.

Next slide. Based on our context, we made a couple of decisions. Number one, because our office at the state health department includes STD control and viral hepatitis, and because we work very closely, we decided to integrate our HIV planning of HIV prevention and care with STIs, particularly syphilis and their general sexual health focus and hepatitis C. We decided that instead of having multiple plans, multiple funding streams, how could we bring them together and use the basis of this NHAS HIV planning, structure, and process to also benefit our viral hepatitis and our STI folks in the office and the program statewide, because we know that so many folks are involved in all of these pieces and that a lot of our priority populations are overlapping.

Second, we decided to organize our integrated plan around the EHE pillars. This is a two-fold reason. Number one, Deborah and I were in charge of EHE planning and now we're also working at integrative planning. We really like the pillars. So it's selfish for us, but also our community of HIV folks who worked on EHE planning in Maricopa County and statewide really liked the pillars. They found that they were very understandable, easy to plan around and very actionable. We've also found from our own experience and the experience in other states that STIs and hepatitis C map well onto the pillars as well. So it's a great way for

us to move forward with this even larger integrated syndemic plan. Third, we decided to keep what worked from our EHE community engagement and planning.

Mostly, this is our additive planning process. Instead of which we just asked for feedback and then gave people a plan, we created a timeline in which we asked for feedback, reviewed that feedback, drafted ideas, prioritized ideas, and then words made our final plan with our community at different places along the year. So they felt like they were involved at many steps of the process instead of just the beginning and the end. Our community really liked that. We got a lot of concurrence on our EHE plan. So we're using our tried and true method now for integrated planning. Next slide. So that was a little bit of our context and how we got to where we are. Now. I'm going to go into what we did to prepare for planning. Next slide. So as of those of you who do planning know it is not a straight line, it is not even a circle. It's like someone took a pen and just scribbled on a piece of paper, but this is a nice simplified version that we can all pretend works perfectly.

Step one for us was internal. In early 2021, we started meeting as an internal state health department team on integrated planning, figuring out what was going on and creating ongoing check-ins and ideas. Step two, we realized we needed to get our partners on board. This included getting buy-in for our syndemic approach and using the EHE pillars. And it was also getting started on tasks like our HIV surveys for our needs assessment, to ensure that we were building partnerships before we actually asked anyone to sit down and write a plan. Step three, we looked at the past. What worked in the previous integrated plan and what maybe we wanted to improve upon. The best part is Deborah was at that plan. She was involved in that process and so we use her historical knowledge a lot to help us figure out where to move forward.

Step four, we started mapping out the future. This meant creating a lot of very complicated flow charts and graphics, looking at guidance, reviewing old stuff, looking at new stuff. We don't use a lot of those complicated graphics today, but they led us to our simplified timeline that we look at every week as a planning team. And they helped us build out who we needed to get involved, where the issues were going to be and how much time we were going to need for specific activities. Step five was setting everything up and getting started. Next slide. So we ran into a few challenges with setting everything up first, we were bringing STIs and hepatitis C into the conversation, which meant more folks, more systems, more planning groups, more everything.

We also try to balance having a big table with a feasible table. As many of you may know, you don't want a group of only three people giving you feedback, but also having a group of 50 people and trying to get individualized feedback from each one of them is also really difficult. So how do you find a good mix? We also wanted the right mix of people and experiences so that our planning groups weren't just stuff members, they weren't just community members.

They weren't just help department members. A little bit of everyone. So our solution was tiered structures in groups. Next slide. So you can see from here that I am not someone who works in marketing or communications. That's why I do what I do, but this is a quick graphic of our tiered system. So we have our oversight committee at the top.

This is sort of our checkbox group. Our checkbox group, the folks who need to be informed, but don't have time for a monthly meeting or providing ongoing feedback. We're thinking about representatives from our Medicaid agency. We're thinking about representatives from each of our Ryan White parts. We're thinking about our co-chairs from all those planning bodies. This group meets four or five times throughout the planning process, mostly to get high level updates and to provide high level input into our plan. Making sure they're all on board. Next here in that middle is our work groups. These are sort of like our sounding boards. They're five or six people each that we've selected from the community and from STIs, hepatitis C and HIV. They represent a diverse mix of folks and experiences. And there really are sounding board to go to for everything.

We're meeting bimonthly with them. And we do a lot more of that in depth work with these folks that we can't do with our oversight committee members. There at the bottom in the gray bar is community, everything else, town halls, planning sessions, community engagement events, surveys, focus groups, all of it. Everyone from tier one and tier two that oversight committee in the work groups is invited to participate in these as well. And this makes sure that we're getting the broad swath of folks, including the folks that we don't know. Members of our planning bodies are involved in all three of these levels, and this has helped us break up what we need to do with what is feasible to do. Okay. I think I've taken more than my fair share of time. So I'm now very happy to pass it over to Deborah to wrap up where we are now and what we're hoping for. I'm turn it over to you, Deborah.

Deborah Reardon...: Oh, sorry. Minor argument there with the mute button. Go ahead and go to the next slide. We're looking at where we are now. So all of those groups that Isabel talked about, the oversight committee, the work groups. We have all those in place now. We have our planning bodies on board. Our needs assessments were finished over the summer. And so now we're doing the long haul of analyzing that data that came in, looking at where we need more information building those focus groups, but doing a big deep dive into that part of the data. Then underneath there is the internal, ADHS planning team. Which is Isabel and I, we have another team member Joanna, and then other team members as we need them. So they can come and go and do their other jobs. But we do all the work of juggling those various work groups and committees. Do all the review, the preparation, compiling everything. So doing all the work in the background and doing all the communication fact. Go ahead next slide. Juggling. We talk a lot about the circus that this is.

Sorry. Minds be a break. Okay. So Isabel already talked a little bit about this, but I wanted to say a little more about those oversight committee and pillar work groups. We have those structures set up. Everybody's been invited. We spent a long time doing recruitment with these folks to make sure that we have the right folks, but also that the groups were manageable size. And we continue to do this as new partners are identified. Shocker, sometimes people leave and so occasionally we do have to replace someone. If the person for HOPWA leaves we have to get their new person on board and get them up to speed with what we're doing. So we are kind of continuously looking for good folks that could come in and help us. We did kick off in orientation meetings in October and November 2021. We brought everybody together.

Did introductions. Had every group come and talk about the planning groups and what we had done before and make sure everybody is on the same page on what we were talking about. So as Isabel said, the oversight committees will meet quarterly. The work groups will meet every other month and everybody will get ongoing email updates and other communication in between to make sure that everybody knows what's happening as we go. Next slide please. Okay. And then our planning bodies. We've set ourselves up to have a standing agenda item on multiple planning bodies. Either Isabelle or I goes to the SWAG, which we also facilitate, but to the Ryan White planning group, to fast track cities, to other smaller planning groups and give those recent updates, share any updates that we might have, get feedback from them and just make sure that everybody's informed all the way along.

And then all of their membership gets invitations to everything else that we do. If we're doing a town hall, we're going to invite those planning bodies. We don't expect everybody's going to come every time, but we do invite them so that anytime that folks want to give feedback, there's a particular pillar or topic that they're interested in, they can be there and help provide that feedback. Okay, next slide. All right. That was our needs assessment. It is moving forward. Like we said, we completed the HIV assessment in 2021. We actually did two surveys. One for folks who were HIV positive, one for folks who were HIV negative. And that way we could ask some different questions. We tried to match them up as much as we could in terms of demographics or insurance, different kinds of topic, but then could ask the specific questions that we needed from each group.

And we're going to call in analysis on that. Hepatitis C and STD or sexual health that have surveys in process where they're being written. The STD one should be launched in the next month or so, and the hepatitis C one right after that is. So we will have that information to include as well, hopefully by the summer. And then our focus groups are kicking off. So we're starting at the end of this month, doing HIV and aging. We'll do another one with folks that are monolingual Spanish speaking, since that's one of the next largest languages in Arizona. And we want to make sure that we talked a lot to different folks. Next slide. Okay, great. Thank you. And that's about our internal planning team. We

have weekly team check-ins usually more often we talk to each other a lot and then we're on chat all the time, biweekly updates to ADHS staff.

So all of those groups that Isabel talked about. HIV, STD, hep C surveillance. We're talking to everybody. We facilitate all the meetings. We're supporting the needs assessment efforts and working with our data folks, and then reviewing those existing facts. We want to take from what already exists and start somewhere. We don't want to start from scratch. We just did EHE and we want to include all of that community input. Was a lot of work from our community and we don't want to lose that. Next slide. This is our timeline, our quote there, the best timeline is a flexible timeline. This does move around a little bit, but this is a general idea. Back in November, did our kickoff. Looking at our existing plans that was done by the internal and then we went back to all of the committees and work groups and showed them what we came up with, told them why, next we'll be reviewing the data. So she still working on that. Pulling information from the surveys, the focus groups, the town hall.

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Deborah Reardon...: ... on that. Pulling information from the surveys, the focus groups, the town halls. In May, we'll do some early planning. We'll have a couple of larger planning sessions. That's when we do our annual conference. We'll do some things there. And then in July, start doing prioritizing strategies and prepping for our planning sessions. We pull this out at every meeting that we have, and we say, "Here's where you're at. Here's what we're doing. What's changed what needs to be added." Then we'll finalize our strategies, start our metrics, finalize metrics so that by November, we're wordsmithing, we're finalizing what we're doing and can start doing some of the internal going through the chain to make sure everything gets approved and is ready to go. Next slide.

Okay. And what we're hoping for from this plan. Next slide.

Okay. Our aims for this? Concurrence. We need concurrence, we want concurrence, we want our community to be happy. Transparency. They should know exactly what we were doing all along, how we got where we are, why what's on the page is there. Lots of communication. We want to make sure that we're always going back to our community and to our planning groups and letting them know what's happening. And then monitoring. With little challenges with our last one of being able to monitor everything in it. And we want to make sure that that's built in this time as well as [inaudible]. Yes. So we want to make sure that that's built right in from the beginning. Next slide.

All right. There we are. If you'd like to reach out to us, you have any questions, there's our contact information. And we've put Karina on there because all of those graphics that you saw in between, that's where it came from. All right. Thank you. We're going to pass this on to... Oh my goodness, Holly.

Holly Hanson: Yeah.

Deborah Reardon...: From Iowa. Okay, so sorry.

Holly Hanson: No, that's okay. Thank you.

Deborah Reardon...: Take it away.

Holly Hanson: All right. Thank you ladies. My name is Holly Hanson. Pronouns are she/hers. And I'm going to share with you a little bit about planning in Iowa. Go ahead and to the next slide.

Okay. So this is a little history lesson slide. I have been in my position for a little over 20 years. So I oftentimes provide context. It really helps me to understand where we're going by looking at where we've been. So hopefully it helps you a little bit as well. So on the left hand side of the slide there, you can see a draft version of what is called the statewide coordinated statement of needs. So for those of you who are Ryan White grantees know that that's the legislative requirement for planning from Ryan White. And then the next one over where it's the red ribbon comprehensive HIV plan. That is an example of a prevention plan. Now it says prevention and care as our community planning group has been merged since about 2001, but really it was a primarily prevention plan. Whereas, the SCSN was really a care plan.

One thing that I wanted to mention when I'm on this slide is how much I not only love planning, but the results of planning. It sounds a little odd to say, but honestly, the first planning process I didn't do well. And then the next one I did and the results are significantly better when you have a plan, when you really involve the people, the stakeholders, the people you serve, community, frontline staff in your plan, and figure out what you want to do in the next three to five years, however long your plan is, it makes a world of difference. And so since about 2005, I have had a really, really strong planning tradition, I guess we could call it.

To the point where in 2010, 2011, got a little rebellious. And we said, the new national HIV strategy, the first one ever, was released and they recommended a statewide jurisdictional plan. And we are a smaller state, we don't have a part A and we don't have any TGAs. So we're like, "This is a little bit ridiculous. We're a small state. We have this SDSN, we have the prevention plan and now we're going to do a jurisdictional plan? No, let's do," what essentially ended up being an integrated plan. We still called it a comprehensive plan there, as you can see. But that plan, we do not let our plan sit on the shelf. We have really people engaged. We talk about their part in the plan. We help them see where they're really critical to now what we say, Ending the HIV Epidemic.

Then you can see that one ended in 2015, the guidance came out around then for a 2017 integrated plan, as you can see our plan on the bottom there for that.

So same thing with that plan, we've come to the end of that plan. And now as you all are, we're working on our integrated plan. Go ahead and go to the next slide.

Thank you. Let's click a couple times. There's some other graphics on there. Think one more. Yeah, one more. Oh, back. Sorry. Yeah. So for this slide, we've talked a lot about the circles on the left there with the national HIV strategy being the overarching plan, integrated plan and Ending the HIV Epidemic plans. You've all seen the documents listed there for the national strategy and the integrated plan guidance. Like somebody mentioned earlier, I do highly recommend you pull that strategy if you haven't done so, it's really helpful when thinking about doing your own planning and things such as strategies that you might want to implement in your own jurisdiction.

Of course, there on the right, is the phase one, Ending the HIV Epidemic initiative. If you know what Iowa looks like, you can see that we are not part of phase one. Though, we had consider doing Ending the HIV Epidemic type declaration, I guess you might say, in our previous plan, but we thought, "No, it's really not the time." But in January of 2019, when the Ending the HIV Epidemic was released, we considered, "Well, maybe now is the time." Next slide please.

As I mentioned, that was released in January, 2019. In the summer of 2019, we had a community planning group meeting and we said, "Even though we're in the middle of our integrated plan, that goes from 2017 to 2021, here's the care continuum. Here's how our epidemic is going." We had started to see a decline in new diagnoses. "We think that we're ready to do an Ending the HIV Epidemic plan." And so we talked to CPG about it. We held a vote and they said, "Yep, I think it's time." So even though we weren't part of phase one, we decided we really wanted to do this because we have this strong planning tradition and we really thought it was the time to move forward. Next slide.

So that was in June of 2019. And so we created a steering committee at the health department and a community co-chair and some other community members to really drive the process and think about what the structure would be like. With an overarching goal of having broader community input than we had even in the past. Even though we were really strong before, we knew that the epidemic had changed to the point where we have a lot of folks, for example, who have full time jobs now, they can't be on community planning group anymore. We still had a full day meeting quarterly. And we knew we were just missing a lot of the community. We knew there were a lot of folks on the front line that we needed to get engaged, that aren't on community planning group, and other forms of ways to collect information. So we're like, "Okay, we are going to structure this a little bit different than from before."

And Arizona touched on this, you learn from your previous planning, how are you going to change and improve? What are you going to keep the same, things

that work before? And that's what we really did. And we presented this structure to the community planning group in November, 2019. It was a three step structure where step one is identifying the structure. Then we gather information for six to nine months. And then draft, review and publish with several different iterations so that community can provide feedback in what we're doing. I loved what it Arizona said about, not just at the beginning and at the end, but all along. So yeah, and at that community planning group, we spent a lot of time collecting feedback from them, they were here, we wanted to take that opportunity to get input from them. So next slide, please.

So one of the things that we did was to brainstorm what strategies do they think would be necessary to end the HIV epidemic in Iowa? And we then categorized them into what, at that point was 10 focus areas, that actually narrowed down to eight. And now we're back up to nine because we added stigma. And I'll talk about that in just a minute. We also agreed on a name. There were a few folks in the community that did not like Ending the HIV Epidemic. So we got to Stop HIV Iowa. So you can see on all of these slides, we have our Stop HIV, Iowa tagline there. So what we said was that stopping HIV in Iowa means 75% reduction in HIV acquisitions in five years and 90% in 10 years. Next slide.

Here's just another look that you can actually see other focus areas. And so they do fall along the care continuum, but really getting at that goal three in the national HIV strategy where we're trying to work on health equities, other comorbidities like mental health, substance use, other social determinants of health, we wanted to make sure to include in there. And then, really important, some workforce issues that we're seeing. We're also pulling in that HCB and STI like we never have before this go around. Next slide, please.

These are pictures of, we had tablecloths on every table with each focus area where folks go around and answer the questions, like who do you think we should talk to? Who are the subject matter experts? What are organizations, specific communities or populations that we should reach out to, to get more information on this focus area? And how would you organize those information gathering sessions? So focus group, a survey, key informant interviews and that kind of thing. And then what data needs can you identify? So then we had it all in writing on these, we were able to get everybody's input and have it in writing. So we thought we were pretty clever. All right, next slide please.

So for each focus area, there are three co-chairs. So there is a health department co-chair, a community member co-chair and then somebody who is serving the community. So somebody from one of our contractors and sub-recipients. Some of the groups have expanded their co-chair and made it more of a team, for example, social determinants of health. It wasn't as cut and dry to move that focus area forward. So they've got a team to work on that, for example. For the co-chairs, we really spent a whole day talking with them on what it means to be a planner, what kind of things we're looking for and their responsibilities moving forward. Next slide.

And I don't think I have time to go through all of this with you, but I wanted you to have this slide so that you can see what we trained them to do to think about training. And it really is so helpful, whenever I talk about training, to think about it as where have we been? Where are we now? What do we need to end the epidemic and how are we going to get there? And then thinking about what are the gaps, barriers, and challenges that are going to get in our way, or are getting in our way? And then we also wanted to really push home that how do we best engage the community? How do we get outside of, we do a lot of planning in Des Moines, we're in the middle of the state, we're the largest city, that's where we are, how do we get out here and some more statewide planning? So those are the kind of things we talked about with the co-chairs next slide, please.

This is a nice visual, it's a decent visual on what I just talked about with where are we now? Where do we want to go? And how are we going to get there? And with identifying those gaps, barriers and challenges so we can think about what our objectives and strategies are going to be. We had each focus area develop what we called a landscape assessment, sometimes we called it the state of the state. So for behavioral health, which I'm a co-chair for, I really just talked about why this is an issue, a problem statement, what are we currently doing around this issue, but what are some things that we want to do to move it forward? What's getting in our way, why don't we just do it? Those kinds of things. And so each focus area ha has done that. Next slide, please.

This is just another example of how we've helped the co-chairs work on each of their focus areas. So we have Google slides and, I'm going to forget all my Google words, but the workbooks, Google Sheets that we can just put all into folders and then be able to collate those. So we had a due date that we had to get our outreach plan together and submitted by September of this year. Because, as you'll see, we had to pause our 2019 planning. Go ahead and go to the next slide.

These are just some guiding principles that we had for developing the outreach and research plans. As you can see, we really wanted to make sure to have a wide variety of voices to be able to contribute to the plan. We wanted, geographic variety, I already talked about getting outside of Des Moines. We also wanted to make sure that we had expert opinions, both lived and learned experience. Because we don't want to reinvent the wheel. A lot of times I talk about, we've done a really good job, I believe, picking that low and middle hanging fruit. What's at the top of the tree? What do we have to do different? What are some innovative strategies that we can employ to really get those top fruit at the tree, right? We also wanted to talk about, considering the impact of COVID-19 and also be a realistic and not overwhelmed folks. Okay. Next slide.

Okay. So this is where, of course, March 2020, everything closes down, we put our Ending the HIV Epidemic on hold, because again, it was a self-imposed deadline. And so we just said, "Now is not the time." Next slide.

Then finally, in June of 2021, we began again and took a look at stuff that we had already done and met with the steering committee to decide, is there anything we need to change? Or can we just pick up where we left off? In June, 2021, the integrated planning guidance was released. And so we decided to merge our Ending the HIV Epidemic and integrated plan together. Next slide.

So we reconvened in December, you can see our focus area... Oh, those are actually different than our focus areas. That was our outreach planning. So different groups wanted to reach out to the same people. So we're trying to coordinate that there. Next slide.

And we are having our kickoff meeting virtually next week already. And so a lot has done to get ready for that. It's going to be an all day meeting and we're going to introduce the planning structure, describe everything that we've done so far and then break out into our focus areas. Next slide.

We are each doing a three minute introduction presentation that we prerecorded last week. So that going to be up and running help with the flow of that day. Go ahead, next slide.

Here's a better view of our planning structure with the updated dates. And so if you want to refer back to that, to how we're doing things, you can see we're on step two now with the information gathering and our kickoff meeting in January. And for the next six months, we'll be really executing those focus groups, forums, surveys, and that kind of thing, and then collect all that, put it together and sort that information. You can see the there's little pictures for each group that's going to be involved along the process. So whether it's the steering committee, CPG, focus area co-chairs or the CPG plus. Next slide please.

Okay. That's it. I'm going to turn it over to Carmi from Maryland.

Carmi Washingto...: Excellent. Thank you so much, Holly. And I appreciate certainly the overviews that both Deborah and Isabelle from Arizona provided, and then you coming in with Iowa, letting me know that Maryland is not off base with where we are going because I see similar activities across the country. I am Carmi Washington Flood. I happen to sit within the Maryland Department of Health in the Prevention and Health Promotion Administration. And I tell people, to have a good way to understand, the administration itself, we deal with everything from rabies to scabies, to babies, meaning we cover it all. Within the Prevention and Health Promotion Administration, there are five bureaus, the Infectious Disease Prevention and Health Service Bureau is the largest bureau. And that is where my office sits and the oversight of the HIV planning group for the entire state. When it comes to community engagement, we believe that it is a space where everybody counts and where everybody contributes. If you'll go ahead to the next slid.

Getting people to the table, making sure that they understand they have a place at the table, of course, is essential for community engagement. And pre COVID, we made space, tangible space for folks to come within the state to a central location. Maryland is made up of what we call 23 jurisdictions and Baltimore City. So technically there are 24 local jurisdictions throughout the state, and we are broken up into five regions. When we were meeting in person, face to face meetings, we would come centrally in the state so that everybody traveled a little bit. We made sure that there was facility access for everyone, regardless of their ableness, and made sure that we had transportation support for individuals who might have needed that, as well as offering childcare support. We did specific invitations because many times people don't come because they're not sure that they're welcome to the table. So we did lots of invitations to local health departments, community based organizations, aid service organizations, other affiliate departmental government agencies, and general community groups just throughout the entire state. And we sent invitations as a mail blast, we did phone calls, we did separate things out on... any kind of way we could get in touch with people just to let them know that they could be there. Go to the next slide, please.

After we had-

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Carmi Washingto...: Next slide, please. After we had those meetings of in person meetings, because again, as has been said, those were all day meetings, like Holly mentioned. Sometimes you have a meeting that is all day, so as one day out of a quarter, the people are able to come together. Well, many times something might happen on those days, or it might not be convenient for the timing, so what we decided to do was to travel to other tables, and we began a process that we called LEGS, our Local Engagement Gathering Sessions, where literally, and as you can see in the graphic, we set up a caravan where we went out from our central location at the Maryland Department of Health across the entire state. And we had meetings twice a year in all of the five regions of the state. We set them up at different times, so some of the meetings were at breakfast.

Some of the meetings were at lunch and sometimes we hosted dinner meetings, but in each of those meetings, we insured that the presence of leadership was there. And what do I mean by that? Our director of our bureau actually was at every single one of those meetings, our deputy director was at every single one of those meetings, myself as the co-chair for the HIV Planning Group for the state representing the government there, we were all there so that as people began to talk in their smaller groups and in their spaces where they were, we not only got an understanding of where their needs were, we were actually standing right in the middle of the communities in which they lived, so we came to where they were and then had them talk with us. And we repeated this over the course of several years, go on to the next slide.

We began planning intentional conversations, so including the HIV Planning Groups quarterly meetings, and then the stakeholder engagement meetings, we said, let's get down to some conversations that pinpoint some of the major concerns that people continue to bring up. We began to look at having conversations around what populations or communities that we would consider most vulnerable or those that might not have access. We started off with a couple of face to face meetings. Two of them initially were in discussing perinatal concerns in aging and older adults. Now, the interesting thing when we began the perinatal conversation that was at the time, the when in focus here in Maryland, it was called the year of the woman, our director at that time wanted us to come into the planning groups and have a discussion around how did we get historically from a place where you might have anywhere from 250 to 300 perinatal HIV cases a year to where we were down to zero, that's major.

And so we needed to sit down and have conversations around what happened, what policies, practices, protocols, what got us to that point with that very vulnerable population and to look and see what was transferable or translatable to some of the other vulnerable communities. We had conversation directly with aging and older adults, where we bought in Medicare specialists and other geriatricians who could talk with us around those specific aging concerns. Then we hit COVID. What happened with COVID? Well, we didn't stop meeting. We wouldn't let that stop us from meeting, but we immediately went into virtual platform mode. And what we found there was that it expanded people's ability to come into the room. We thought we were also going to have to shorten the meeting length, which we did. We took it down from about six hours for the day, but took it to a four hour day. People at first were wondering how in the world are you going to capture folks' attention for four hours in a Zoom room?

Well, believe it or not, because folks are so well invested and they are so passionate about assisting and helping. Not only did they show up, but they stayed the entire time. We had several stakeholder, what we call stakeholder engagement series with gender affirming communities, so the LGBTQ community, African American community, Latinx community, and youth. Go on to the next.

We also came into the year after E2E plans came out having jurisdictional reviews, so there were three E2E jurisdictions, Baltimore City, Prince George's County, and Montgomery County that all received special funding that came out under the E2E strategies with their responsibility to develop plans specifically to spend those dollars they had to devise something that was broader than the already existing [inaudible], an integrated plan for the state of Maryland. We had them come back again in a very specific space and gave meeting time to each of the jurisdictions to share those plans with the rest of the state. We gave set up separate meetings for folks to come in and just talk about what their plan was, how they planned to roll it out, who was going to be involved, and those goals and objectives that they had to reach further than what they were already reaching.

Go on to the next, what we found is because Maryland as our director so fondly says all the time, Maryland is really the United States in miniature. We may have large cities, but much of Maryland is rural. We go from mountainous areas all the way to the beach. We have rivers and valleys, mole hills and mountains. All of that is right there in Maryland, so you can't miss the elephant that's in the room. If there are three jurisdiction that receive special funding, what happens to the 21 jurisdictions that did not receive special funding? They are not stopping their activities when it comes to addressing HIV, they actually have things that are in sight that they have to reach. They also are still in the fight and guess what? They actually have some rights to come in and say, we want to partner. We want to have targeted funding. We want to also be a part of the overall plan. And we have a say in what's going on, so while we set up the LEGS where we went out, guess what?

We modified that just a little bit. And we actually had LEG-INS Local Engagement Gatherings In what we call Neglected Spaces, because they did not receive some of that special funding, so very specifically with our Southern Region, Western Region and Eastern Region, which are much more of the rural areas of our state, we took to them the E2E plans from the larger jurisdictions. And we walked through and we said, what's missing from you? What is not represented or what does not speak to your particular need? And as was mentioned by Holly, that they had to make another category for stigma in some of their conversations, what we found in some of the rural areas, they said, stigma is not our big issue.

Guess what? The lack of infectious disease docs is our issue. Stigma isn't an issue, access to testing is an issue. Stigma is not an issue, available services are an issue. It became much more important for us to give space to these smaller jurisdictions so that they could also pinpoint what were their specific concerns to address the populations that they were serving. Let's go on the next slide. Integrating issues and concerns. We said, we can't stop the conversation because of course we all are in a timeline for the new integrated plan that is going to be put underway for the next five years coming, so we did start off as I said, with getting people to a central table, then we went out and met folks at their table. We then decided to have the jurisdictional and stakeholder engagement series. Then we said, guess what?

We need some ongoing conversations. And we have now put in place what are called our HIV Planning Group CELLS, Community Engagement Live Listening Session. We believe it or not meet every other week. We meet every other week, biweekly to have conversations with the community around very specific and consistent concerns that have come up in surveys, feedback from all of the other meeting notations that have been had, because we want to meet around these key topics that continue to come up through all of the other meetings. 12 topics and or vulnerable groups continue to rise to the top. Things like housing, prep, transportation, research, aging and elderly populations, youth, same gender loving men, transgender populations, Latinx, African American, and women. We also are holding off a series of meetings where we say, if something

continues to pop up, even in these biweekly meetings, we will have space for that as well.

What happens there? Each meeting, each topic has three meetings that are focused on that topic because we know that a lot of times people can come and you end up stopping because folks just want to talk about the problem, so we assign the very first meeting for every topic, just to talk about the problem. What are the issues? What are the challenges? What are the concerns that come from the entire state and everybody is invited to the table. Then we move to the second meeting to say, now that we've heard about all of the concerns, all of the issues, and the challenges that are there. Let's look at, what are some of the things that you would like to address? What are those practices, activities, action steps that you would like for us to take? By the time we get to the third meeting, we are asking for the priorities out of everything that has been recommended in that second meeting, let's get some priorities. What are the three to five things that you definitely want to see happen?

And then again, our director, we don't let them shy away. We say, give us some clear marching orders, so what can be phased in? What do you see us doing within the first six months of the integrated plan? What do you see happening within the first 18 months? What do you see happening within the first three years? So that as we are planning the plan, we are also getting marching orders from the community directly so that our expectations, as well as our ability to evaluate our activities are being built in right from the begin. Go on to the next one. Timelines and finishing touches. Look, this is where we are. We began these biweekly meetings in October of 2021. We have a calendar that is running through June 2022, where these biweekly engagements are happening, plus we have continued to retain our quarterly planning group meetings. At the quarterly planning group meetings everything that has been discussed and prioritized is revisited at the quarterly meetings, so that by the time we get to June, we will really have a draft of the plan already in place.

When we get to June, we are looking for that we will give this to our E2E director and other staff members who are working on the plan. They will develop a plan for review on the priorities that have been set, the phased in timelines that have been spoken, and hitting all of those major concerns that have continued to be discussed all along. We will submit that draft plan to our state department leadership in September, from that point we will be working on getting group consensus and then final submission to our federal partners. We know that it is, we said it's an ambitious endeavor, but we know that our folks and our staff throughout the state are not only well up to that challenge, but they are meeting us literally at the table every two weeks, so I'm going to wrap that up because the next slide should be my contact information. And then Holly, I'm going to pass it back. Molly, I'm going to pass it back over to you at [inaudible].

Molly Tasso: Great. Thank you so much everyone for these wonderful presentations. It's so fascinating and really encouraging to hear about everything, the great work being done across the country. We have time for, I think one question, so I am just going to quickly read out the question and then we're going to wrap up. And in my wrap up, I will be giving everyone the information for our future sessions, but we do want to get this question out there, so here it is. Our part A's, so whoever asks this question, the part A's in this person's state are quite independent of the part B's making coordination and information exchange more difficult, any assistance in trying to get the part A's and B's to coordinate better? I'm going to hand it over to Isabel and Deborah to tackle this one.

Isabel Evans: Yeah. Hi, once again, Isabel. I'm with Arizona, and this is a great question. I think I have an example. I think Deborah has one as well. I will sort of start this off with saying that we have a really great relationship with our part A and because we're in the same city, pre-COVID we were able to see each other go to each other's meetings. And that has really helped with getting to know each other. A specific example of something that we use to better work together is finding ways to leverage work, a example of this that is actually tied into integrative planning is in 2021, as we were working on the needs assessment for the integrative plan and thinking up how we were going to do our statewide surveys, we actually reached out to our part A and said, Hey, we need to do a statewide survey.

And we know that for your part A reports and for your part A allocations, and resource allocations in PSRA, we know that you need to gather information as well. Can we combine forces and write a survey together that's going to check off boxes for both part B and HIV prevention, as well as part A? They said, yes, we would love to not have to do our own survey and do our own data and send surveys to the same people, so we partnered on our surveys and it was a little longer than it would've been if each of us had done it on our own, but we only had to send out one statewide survey. We got the data that they needed, and we were actually able to get a better representation across the state because we had worked together.

And so I think for us, when we find projects that we can do together, trying to intentionally do that has been really, really helpful. And I think has also transitioned into helping each other out with, Hey, you're doing this program, but you can't pay for that, so let's pay for that. And all those sort of in-betweens where we can leverage each other's work so that we can provide services to each other, instead of just asking for things which has really helped benefit our relationship and we also, we meet regularly. Deborah, do you want to talk about that really quick?

Deborah Reardon...: Absolutely, so during EHE, we started having biweekly meetings with part A, because they were doing an EHE project, we were doing an EHE project. And so every two weeks we got together, we talked about where we were. We invited them to our community groups they invited us to theirs, so we just stayed really

well connected during that. But then we kept those biweekly meetings going so that as we went into the implementation phases with EHE we were still meeting, we were talking about what's going on, we were helping troubleshoot problems for each other, all that kind of thing. And so once Integrative Plan started, but EHE was pretty smooth. We continued having those meetings and just sort of transitioned them over to being more about Integrated Planning and less about EHE, but we also throw in all of the other activities that are happening between part B and part A [inaudible] prevention and those two groups, so that we all feel like we're really well connected and it gives us a better chance.

Sorry, my cat. It just gives us a better chance to really kind of stay in touch and work better together. I think over a couple of years of that it's strengthened our relationship and everybody feels like their stuff is important while we're still working together. And we've actually wrapped up this meeting now that's where we're going to go, is to that meeting.

Molly Tasso: Wonderful. Thank you so much, so next. Perfect. Thanks Julie. As I mentioned today was really sort of the beginning of our learning series that we are hosting. And so we really hope that you will continue to join us for our upcoming events. The First Peer Learning Session is Monday January 31st from 15:00 to 16:00. And this will really be a continuation of the discussion that was started today. There will be no slide presentation and participants will have the opportunity to ask questions that maybe we didn't get to today, to share their approaches, to gearing up for Integrated Planning and engage with colleagues and stakeholders from across the country. And then our next webinar Making the Case with Data is focused on the section three of the Integrated Planning guidance. And it's scheduled for Thursday, February 17th at 15:00 PM and all of the information and the registration links for these events and all of our learning series events are on our website right there on this slide.

And then on the next slide, thanks. We acknowledge that Integrated Planning might feel a bit daunting, but we want to assure you that IHAP TAC is here to help. And so if you're new to Integrated Planning and might like a refresher, please start with our introductory online module, which provides a really wonderful overview of the entire planning process by way of a self-paced online course. And if you aren't sure where to start or perhaps want some sort of guidance in terms of figuring out what you need to get started, please visit our website, subscribe to our mailing list, take a look at all of the resources and tools that we have available, or request tailored technical assistance. And again, all of this is on our website. Thank you so much for joining us today. We are at time. It would be wonderful if you could take a moment and fill out the evaluation form that will pop up in a moment. And just again, thank you so much for joining us and thank you to our wonderful speakers. We hope to see you all soon. Have a wonderful afternoon. Thank you.

PART 4 OF 4 ENDS [01:30:09]