Molly:

Good afternoon, everyone. And welcome to this afternoon's webinar, Charting the Course for the Next Five Years: 2022 through 2026 Goals, Objectives, and Strategies. This is the fourth webinar presentation in our series of webinars and peer learning series that is walking you through the new integrated planning guidance section by section, and helping to prepare your jurisdiction to develop your new integrated plan for years 2022 through 2026.

Molly:

If you want to go to the next slide, thank you. So the IHAB tech began in 2016. And since then, we've supported HRSA HAB Ryan White parts A and B recipients. CDC DHAP funded health department recipients and the respective HIV planning bodies. We conduct national and individualized training and technical assistance and 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.

Molly:

So it's hard to believe that we're already in month five of this webinar and peer learning series. And then if this is the first time you might be joining us, this series is intended to review and discuss the new integrated planning guidance section by section, highlight jurisdiction efforts, address emerging and ongoing questions, and facilitate peer engagement and learning specifically through the peer learning series, sessions rather, during which participants have the opportunity to further connect, share and discuss challenges and strategies as it relates to the development of the integrated plan. You can find more about the upcoming events, including next week's peer learning session on our website, targethiv.org/ihap.

Molly:

So today, our goal is that you leave this presentation being able to articulate the changes to the joint CDC and HRSA EPI profile guidance, understand how to meet submission requirements for section five of the integrated plan, describe the benefits of creating SMARTIE goals and objectives, identify best practices for developing integrated plan goals and objectives, and also understanding and knowing how and where to go to access IHAB Tech resources. So today, I'm just going to get us started with a few poll questions after I'm done with this introduction. And then I will provide a quick overview of the updated EPI profile guidance. I'll then hand it over to my colleague, Gretchen, who's going to provide an overview of the integrated plan, section five, followed by a presentation by the Tampa-St. Petersburg EMA. And then we'll go ahead and wrap up with the Q&A, and I again, will provide some details for the next peer learning series.

Molly:

Throughout the webinar, please do use the Q&A function in Zoom, which is located at the bottom of your screen and shown here on the slide. To ask any questions you might have, please ask questions throughout the presentation. And then again, at the end, we will go ahead and do our Q&A.

Molly:

So we have two quick poll questions here. So this first one, were you involved in the development of the 2017 through 2021 integrated plan or involved in that planning process? There we go. So what we've been seeing on our webinars is that we've been having quite a few folks joining us who were not involved in the last planning process. So we are excited to have a sort of new cohort of health planners on here learning about the integrated plan and the sort of process putting this together. And yeah, it looks like we can go ahead and close the poll and share the results, looks like today similarly.

Molly:

So almost 70% of you were not involved in the planning process last time. So we are very happy you're here. Welcome. And again, please ask any questions you might have related directly to section five or generally about the Integrated Plan Guidance or the planning process.

Molly:

The next poll, if we could get that going. So this is sort of specifically related to today's topic. So has your jurisdiction made a decision related to the organizing principles of the goals and objectives? So what we're asking is sort of the NHAS versus the EHE strategies. Yes, no, totally fine if you're not sure yet, or if your jurisdiction hasn't made a decision yet.

Molly:

We'll give folks a few more moments to respond, but it looks like we can go ahead and close the poll. It looks like 40% of you are not sure. And another quarter of you have not made a decision yet. And about 8% sort of definitively has not made a decision as to how to go ahead and organize the goals and objectives. So this is all very helpful. Again, my colleague Gretchen will get into the sort of nitty gritty of section five after I'm done, but thank you so much for participating.

Molly:

So again, before we move into section five, I'm just going to provide a really quick sort of update on the updated integrated guidance for developing EPI profiles. So on the next slide, as a reminder, CDC and HRSA developed and released the integrated guidance for developing EPIdemiologic profiles first released in 2014 and then updated and re-released in March of this year of 2022. As you know, developing EPI profiles is a programmatic requirement for CDC DHAP recipients and Ryan White Part B recipients. And it's a legislative requirement for Ryan White Part A recipients.

Molly:

So this guidance sort of helps in this endeavor by providing one set of guidance for jurisdictions to use when developing EPI profiles. It advises profile writers on how to interpret data in ways that meet the planning and evaluation needs of both prevention and care programs, and ultimately, sort of with the goal of helping to reduce duplicative evaluation efforts of health departments and planning groups.

Molly:

The EPI profile guidance is organized into five chapters, which is then broken down into sections. The first chapter describes the purpose of the guidance, identifies audience for the documents, and outlines, what end users will learn. Chapter two describes how to determine the scope, content, and organization

of the profile. The next chapter describes four domains, which then contain a total of nine core EPI questions that are intended to help describe the general population and the population of persons with HIV in a jurisdiction. Chapter four, then describes how to make the profile user-friendly and approaches for writing the narrative and disseminating the profile. And then finally, chapter five addresses, sort of considers special issues that may arise during the writing of the profile, specifically looking at special needs populations, comorbidities in areas with low morbidity and minimal data.

Molly:

The updated guidance contains a few key changes. So first are recommendations and examples for incorporating data on the social determinants of health, that act as barriers to HIV prevention, testing and care. And this addition is really in response to the continued concentration of new infections among certain populations impacted by social determinants of health, and is really an effort to support reducing these health disparities. And then the second change is related to the list of core questions that I mentioned earlier that should be addressed within the EPI profile. So in addition to the inclusion of a handful of new questions, the updated guidance contains sort of greater inclusion of social determinants of health and stronger emphasis on HIV-related disparities and health inequities.

Molly:

So for example, in the 2014 guidance, the first guidance, the first core question asked, what are the sociodemographic characteristics of the general population in your service area? And the first core question in this updated guidance that was released asks what are the demographic characteristics and social determinants of health among the general population in your service area? So those are the types of changes that we're seeing in the new guidance.

Molly:

All this to say on the next slide is just before we move on, a reminder that the integrated planning guidance does not require the submission of a full EPI profile. It asks for and requires that jurisdictions submit as a part of the plan, an EPI snapshot. And so this is a snapshot. The snapshot is a summary of the most recent EPI profile within a jurisdiction. It provides key descriptors of people diagnosed with HIV and at risk for exposure in the jurisdiction, and does provide specifics related to the number of individuals with HIV who do not know their status, as well as demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at risk for exposure to HIV.

Molly:

So we did sort of discuss this. We discussed the EPI snapshot as a part of this webinar series. And at the end, I can uphold the link from our website to share with you the slide deck and recording of that particular presentation if you're interested in digging in a little bit deeper. But we just wanted to recognize and acknowledge that the EPI guidance had been updated and provide you all with a pretty brief snapshot of that. So with that, we are going to turn back to the integrated plan and dig into section five. So I'm going to hand it over to my colleague, Gretchen, who is going to kick this off.

Gretchen:

Great, thanks so much, Molly. And hi, good afternoon to everyone very glad to be here with you today, talking about this section of the integrated plan. While this section of the plan is the primary focus for

today's webinar, it is definitely something that we have been talking about throughout the webinar series and really since the guidance was released, in part because it has raised a number of questions about whether or not the section should be organized by the EHE strategies or the NHAS goals. So it's really been a topic of conversation over nearly the past year since the guidance was released, and looking forward to going through it with you all in even more detail today, and then turning it over to hear from the Tampa-St. Petersburg EMA about how this is playing out in their jurisdiction. Next slide, please.

Gretchen:

So we've included this figure in every webinar in the series thus far as an important reminder that the integrated planning process really extends beyond this immediate 18-month long integrated planning period that we're all in right now. And so after plans are developed and submitted, it will move on to the stage of implementation, monitoring, updating and improving the plan, and then communicating and sharing progress. And I think that this is always an important reminder that it is not just about the planning process. It is then something to actually implement and monitor.

Gretchen:

But in the process of developing your goals, objectives, activities, really thinking through what it will look like down the road to actually be implementing this plan, how are you going to measure what you are achieving? How will you know if you're achieving success? How are you going to sh share the success or challenges with your partners and stakeholders in the community? And so thinking about that very actively and intentionally during plan development so that it truly is a very actionable plan, not one that just sits on a shelf or in a file that doesn't frequently get opened. Next slide, please.

Gretchen:

So to dig into the section, goals and objectives should reflect strategies for unified coordinated approach for all HIV prevention and care funding. This is a comprehensive plan for the jurisdiction. It may not be the only plan in the jurisdiction, but it is intended to be a comprehensive one of the HIV service delivery system. The goals and objectives should address and reflect a focus on health equity, as well as intentionality to address barriers and needs that have been identified throughout this planning process that you've been undertaking.

Gretchen:

And then similar to a number of other sections in the integrated plan, jurisdictions may update or use portions of other plans. There is likely not something that you can use without making any updates to it. So as an important reminder, if you have an existing plan such as an EAG plan for a county, and it's going to be used in part for this integrated plan development, it certainly needs to be expanded so that it would speak to the entire Part A jurisdiction, for example. And then if you are using an existing plan or portions of existing plan, it is important to describe the changes you have made so that it is up to date and meets the requirements of the integrated plan submission. Next slide, please.

Gretchen:

So in terms of goals and objectives, they should be written in SMART format. This text on this slide is coming directly from the guidance, so they should be written in SMART format. And later on in my presentation, I'll talk a little bit about SMART versus SMARTIE format. And they should be structured to

include strategies that accomplish the following. And here, we see the four areas of diagnose, treat, prevent, and respond. And in regard to these four areas, we have commonly come to refer to them as the EHE strategies or the EHE pillars, but I think it is worthwhile to point out that they are not explicitly referred to that in the guidance. The guidance certainly acknowledges the EHE initiative, as well as the influence of the National HIV/AIDS Strategy, but they are being referred to as the four areas.

Gretchen:

And I think that is a really important point because there was some confusion and certainly some questions, particularly shortly after the guidance was released, that sort of indicated that maybe these strategies, these focus areas were only for the EHE jurisdictions participating in the EHE initiative. But I think increasingly, we've seen these four areas or these four strategies being used to describe our overall structure and approach to ending the HIV epidemic, achieving the goals of the National HIV/AIDS Strategy, so not to be boxed into a place that sort of just belongs to those EHE jurisdictions. You will hear, certainly throughout my presentation, kind of going back and forth between referring to them as the four areas or the EHE strategies. Next slide, please.

Gretchen:

So a few words on some of the specific section requirements. The text here in this bullet of including at least three goals and objectives for each of the four areas comes directly from the guidance, from that Appendix 1 section of the guidance. And I really wanted to raise up one of the questions that's included in the Frequently Asked Questions document that CDC and HRSA released about how many goals should the jurisdiction include for each of the four focus areas. And you'll see that in the response from CDC and HRSA they've added or, and inserted a slash. So there should be at least three goals and/or objectives for each of the four focused areas.

Gretchen:

So there is a terminology and a taxonomy issue that we'll get into in the slides to come. But the point here being that goals and objectives can be used interchangeably when looking at how many items do you have associated with each one of these four areas. And that would be at least three. Next slide, please.

Gretchen:

So then this question of format, and again, drawing here from the FAQ document that was released by CDC and HRSA, a number of months ago after the release of the guidance, and the question of how should goals and objectives be ordered. Should jurisdictions mirror the NHAS goals or the EHE plan? And certainly we know that a number of jurisdictions, maybe many of you on today have had this question and potentially still have this question. It was somewhere around, less than half, maybe looks about 40% that said, no, you haven't decided how you were going to structure your goals and objectives yet. So this might be particularly helpful for you.

Gretchen:

There is no required format. And that last section that I've underlined there, I'll jump down to that, to say that CDC and HRSA do note that jurisdiction should really determine what structure for your integrated plan is going to work best for your jurisdiction, support full implementation, and allow for

concurrence. So there is certainly a strong encouragement to use the sample template that is provided in Appendix 2. We'll get to that in just a moment, but it is not required.

Gretchen:

Now, if we go onto the next slide, what you'll see here is that sample template. And when you first received and looked through the Integrated Plan Guidance, for some of you, this template might have looked very familiar, as it is the template that was given as an example in the planning guidance for the EHE jurisdiction. So this is certainly borrowing from that. And this is copied and pasted, a screenshot from the appendix, and the point here being really to highlight that the sample template in Appendix 2 follows the four areas. So it uses the four areas or the four EHE strategies as the organizing principle for the plan with goals and activities under that.

Gretchen:

So by this example, you could see that you might have at least three goals under Diagnose, and then the specific activities that you will undertake to achieve those goals, again, with the opportunity to have goal and objective be somewhat interchangeable as it relates to how you actually label and structure everything. But Appendix 2 is structured to organize the plan around the four focus areas or the four EHE strategies. Next slide, please.

Gretchen:

So there is an explanation of terminology from the National HIV/AIDS Strategy that I actually find quite helpful, and hopefully you will too, in thinking about kind of the taxonomy and the ordering of goals and objectives and activities. Again, this is offered up as a way of helping to think about what is going to work for your jurisdiction, not intended to any way dictate exactly how you do it.

Gretchen:

So the National HIV/AIDS Strategy describes objectives as providing direction for the attainment of the goal. So we know that NHAS has four goals, and they are these big overarching guiding aspirational aims, and the objectives fall underneath the goals as a manner of providing in more detail, what exactly is looking to be achieved in order to aspire towards that goal. And then underneath the objectives, there are the strategies, which represent the approaches to achieving the objective.

Gretchen:

And a note about NHAS is that it does not include activities. It includes strategies. The activities are reserved or saved for the Federal Implementation Plan that accompanies the National HIV/AIDS Strategy. And then I also think this last detail, this is pulled directly from, from NHAS is an important one, which is that they acknowledge that numerous objectives and strategies could fit under more than one goal. However, each one has been placed under the goal with which it most closely aligns. And I expect that many of you are experiencing this in your jurisdictions or will as you put together plans, particularly with a focus on status, neutral approaches, so needing to find a best fit per for a particular goal or objective, but certainly knowing that there is overlap, whether you organize by the NHAS goals or by the EHE strategies or something else, you determine best for your jurisdiction. Next slide, please.

Gretchen:

So this is a nice table from the NHAS that goes along with that explanation of terminology to describe how they situate objectives underneath goals. And then I think for the purpose of the integrated plan, the sort of strategies and action steps are almost one and the same to say, what is it that you are going to do to achieve those objectives in service of achieving your overarching goals?

Gretchen:

And so this is a lot of terminology. This is a lot of sort of language that can feel very similar. So please, I am not looking at the chat box or the questions right now, but please share your questions. And we can discuss more in the Q&A. And we'll certainly hear more from our guest presenters. And please in the chat, feel free to also share what you are doing or considering doing in your jurisdiction as it relates to organizing this section of your integrated plan submission. Next slide, please.

Gretchen:

So very quickly, I think, describe your approach. You could also say, show your work. Tell the reader, let CDC and HRSA know in the integrated plan, how you have chosen to organize this section so it's clear to everyone. Indicate which of the four areas your goals and objectives are associated with. Even if you are not using the four areas or EHE strategies as you're organizing principles, you're going to want to be able to show how you have at least three goals and/or objectives per focus area.

Gretchen:

So I offer here, two very, very simple examples of what this could look like. You might include in your integrated plan that similar to Appendix 2, our plan organizes our goals by the four areas and that there are at least three goals for each area. That example very closely mimics the structure provided in Appendix 2. Or you might say that our plan organizes our objectives by the four NHAS goals. For each objective, we indicate which of the four focus areas it is most clearly or directly aligned with. See table 1 for a summary of the objectives for each of these four areas. I will note that is not at all a requirement, but it is offered as a suggestion that if you are not using the four focus areas or the EHE strategies as your organizing principle, in addition to labeling how your goals and objectives fall under those four categories, you could also create a little summary table of that, or just a bulleted list. Next slide, please.

Gretchen:

And this is my last one before passing it onto our guest speakers. So for quite some time, we talk about SMART objectives, SMART goals. They are specific, measurable, achievable, realistic, time bound. But increasingly, we are talking about the development of SMARTIE goals and objectives. The I is for inclusion. It provides an opportunity to bring traditionally excluded individuals and groups into processes, activities, and decision making in a way that shares power. And the E for equity means including an element of fairness or justice to adjust systemic injustice in equity or impression. And the definitions on the slide here come from the resource that we've linked to on the slide.

Gretchen:

And that's available in the companion guide among others for supporting the development of SMARTIE goals and objectives. And given the requirements in the guidelines or in the Guidance for the Integrated Plan to Address Health Equity, and to be inclusive in the planning process, we certainly encourage consideration for how you can make your SMART objectives SMARTIE, really building this in from the beginning of the plan's development to support how it is carried out throughout implementation

monitoring, and also the communicating and sharing of progress to all of your partners, stakeholders, and community members.

Gretchen:

And so with that, next slide, and I'm really pleased to turn it over to Naomi and Katie from the Tampa-St. Petersburg EMA, to talk to us about what this looks like and how it's shaping out in their jurisdiction. So Naomi and Katie, over to you.

Naomi:

Thank you so much, Gretchen. This is Naomi Ardjomand-Kermani. I use they, them, [neopronouns 00:32:07], and I am one of the co-managers for the Ryan White Planning Program within the West Central Florida Ryan White Care Council. I'm going to throw it over to Katie, because she'll be starting off our presentation.

Katie:

Good afternoon, everyone. I'm Katie Scussel. I'm also one of the Ryan White planning managers at Suncoast Health Council. And I've been working in planning council support for the Tampa-St. Petersburg EMA for the past five years. We can go on to the next slide.

Katie:

So we're going to be talking about some of our experiences with the past integrated plan, the 2017 to 2021 plan, and then lessons that we learned from that plan that we are incorporating into the plan we're currently writing. So for a brief overview of our EMA, the Tampa-St. Petersburg EMA is on the west central coast of Florida. It's made up of four counties, Hillsborough, Pinellas, Pasco, and Hernando. Within those four counties, we have a total of about 14,230 people with HIV. And of those four counties, Hillsborough and Pinellas, which you can see in the green and blue on the map are more urban areas. They're very densely populated. So in addition to our Part A grant, those two counties also receive EHE funds.

Katie:

And in Hillsborough County, we actually have two different lines of EHE funding. We have both CDC and HRSA/EHE projects. So with all these different lines of funding in our area, we have a variety of different planning groups and stakeholder groups that we're collaborating with on our integrated plan. Our local Part A Planning Council is the West Central Florida Ryan White Care council. And it is a combined Part A and Part B council. So we have an additional four counties that we also have represented on our planning council. The integrated plan we're working on, it is our EMA plan that we are submitting to HRSA. But on top of that, we are also working in parallel with the state of Florida for the statewide integrated plan. And you can go onto the next slide.

Katie:

So for the 2017 to 2021 plan, this plan was written in 2016. So Naomi and I started in our roles right after the plan was written. So we weren't involved in the actual process of writing it, but we did come on at a time when it was needing to be monitored. So we actually borrowed a really nice monitoring tool from Miami-Dade County EMA. And then we adapted that tool to fit our needs. And we used this tool to

report the status of our plan goals to our planning council's Planning, and Evaluation committee. You can go to the next slide.

Katie:

So this is the monitoring tool. This is just a snapshot of one of the strategies. So we have the NHAS goal up at the top, and then you can see our objective all the way at the left. And then it goes into the strategies and the different activities we had to meet those strategies. And we identified the responsible entities for each activity, and then the data indicators that we were using.

Katie:

The full document was color-coded like you can see in green. So we had green for areas where we had met our target, and then yellow for where we were on track to meet our target, but hadn't quite reached it yet. And then in red, we had for areas where we were experiencing any barriers or just areas where we were not on track. And this color coding gave us a really nice visual tool to be able to see where we were with each strategy. You can go onto the next slide.

Katie:

So when we started the monitoring process, what we found was that some of the strategies we had written into our plan that had been written into the previous plan, just couldn't be measured, whether that was because they either lacked baseline data, or the data indicator we had planned on using to capture that strategy was something that no one in our area was actually keeping track of. And we found at times, there was just a lack of a clear roles and responsibilities when it came to that data collection. Part of that was due to staff turnover because not only were Naomi and I new to this plan, but we also had staff turnover at our local health departments and in our service provider agencies. So even though when this plan was written, we may have had individuals at the table who said they could provide certain pieces of information we would need, some of those same people were no longer at the table again, when it came time to do monitoring.

Katie:

So in response to these challenges, we revised our plan and we turned it into a living document that we could update as necessary. We kept the overarching objectives, but changed some of the activities that we would use to meet those objectives so that we could capture what we could actually track. So with that, Naomi's going to talk more about how we brought lessons we learned from this experience into our planning process for the 2022 integrated plan. So you can go to the next slide.

Naomi:

Thanks, Katie. So one of the things that we really saw was a necessary addition was of course, community involvement and input, which is part of our integrated plan needs assessment. But we really wanted to have an emphasis on community responsibility. We wanted to shift our planning body so that we could shift the culture of our planning body as well, so that individuals who may not have felt welcome in the room or may not have felt represented in our room would feel more welcome in our space at the care council. We wanted to make sure that in doing so, we were intentional. So we created a cultural competency or a cultural humility, whatever you would like to call it, skill series.

Naomi:

We had workshops that were about race and equity in our local area, about gender sexual orientation, about disability and ableism, and we're going to continue that series as we move forward. We're really hoping that perhaps the sex worker out outreach project for example, will be able to come out and speak more when it comes to the needs of the sex worker community. Because we know that those are one of the populations that we have not really addressed, I think as a whole.

Naomi:

In addition, in the former iteration of the integrated plan, now, understanding that HRSA was not collecting that data at the time, however, with that plan being 2017 to 2021, we were lacking data or any goals and objectives that were specific to the transgender community. Coming into this position as a transgender individual, it was very disconcerting, and it was for other transgender individuals who came into this process or joined our care council to flip through that integrated plan and see nothing about them. So as one would assume, if you don't see yourself somewhere, then you're going to excuse yourself.

Naomi:

So we lost a lot of people that would've been incredible voices. So we needed to change ourselves. And in doing so, we felt that we would be more successful, first of all, when it came to inclusion, as well as equity, I love the SMARTIE goals, the way that we've switched that around, I'm all about it. The goals that we did have trackable data for format successfully. But like Katie said earlier, there were some communication issues among different departments, within the Department of Health and other entities.

Naomi:

So for example, trying to get numbers of individuals who access prep was difficult because the early intervention services weren't really in a communication process when it came to the prevention aspect of DOH. There wasn't just a clear line of communication, and trying to track that data was like trying to herd cats. So really, we had to focus on who can we get data from in spite or despite things like staff turnover, et cetera. Next slide, please.

Naomi:

So with our 2022 integrated plan process, we began drafting this plan as soon as possible. We started in January with creating the writing team and also creating a very specific timeline for the writing team, assigning out sections. And we've been meeting those deadlines. We've actually almost completed all of the sections in terms of drafts, and we're working on those second drafts as well. The first couple of drafts have been sent to the care council for their review, such as the community engagement process section. And we presented it, they had no questions, but we are anticipating that a lot of those questions are going to come up when we're talking more about goals and objectives that they want to see in addition to what we see.

Naomi:

So we are ongoing just making sure that we're communicating with our care council members, as well as the community at large. We want to hear from them. So we started doing town halls on a monthly basis. We had several opportunities where we had group discussions. You may have noticed in one of the earlier slides, it said that we reported the monitoring progress to our former planning evaluation

committee. We had decided that under COVID and under quarantine, because we have to follow the Sunshine Law, that we would need to reduce the number of individuals that would count for an in person quorum. And we did so in changing it from 50%, plus 1 to 33% of members in person.

Naomi:

We wanted to also make sure that everyone was involved every step of the way when it came to this planning process. In the previous iteration, the planning and evaluation committee was specifically responsible. And anything that they determined or decided to forward onto the care council was then reviewed. I don't know about you, but if somebody sends me something and says, I have to vote on it, if I wasn't a part of the process, I'm either going to a, recuse myself. Or I'm b, going to say, I don't even know what we're doing, I'm just going to say yay. When we get to the yays and nays.

Naomi:

So we wanted everyone to be involved. This is the work that we're doing. We also really wanted to shift the attitudes that we saw within care council from, well, how do you describe it? Boring. That's not what we want to hear. We want to hear these are the decisions that we're making to fund those programs that are boots on the ground activism. We have convened regular writing team meetings. And specifically by sections, we're not asking everyone to be a captive audience, but for those individuals who are assigned specific sections, we have ongoing meetings, even if it is as simple as, I have a couple of questions when it comes to these goals and objectives. Okay, teams meeting, we've got it going. We've asked planning council members to join. They've come in and out as we expected with this part of the process. But with those goals and objectives, we're really looking forward to hearing more from them. Next slide, please.

Naomi:

So for those lessons learned, we did the town halls. We are having those on a monthly basis. We also had a focus group-style town hall back in March, if I'm not mistaken. And that was in preparation for the Florida Comprehensive Planning network or the state's meeting in the spring. They wanted to hear from us. They wanted to gather meaningful information, really following those MEPA standards of meaningful involvement of people living with HIV and AIDS. We hear it all the time, "nothing about us without us." Well, we need to make sure that we have us there.

Naomi:

So we've also updated our language. We know that language evolves over time, and we cannot pretend that is not happening. We have to make sure that our language is evolving as well. So that meant going from stigmatizing language to non-stigmatizing language. For example, one of those things would be instead of injection drug user, someone who uses injection drugs. All of these different pieces that seem so small when it's language are really so big when you feel excluded or stigmatized.

Naomi:

We are going to be regularly monitoring as soon as possible so that we can make adjustments as we need to. We're going to continue to hold this as a living document so that changes can be made at any point in time, but we want to start them off in a really good solid space. Next slide. I think we actually are at the end of our slides.

Naomi:

So I want to thank you so much for having both myself and Katie come out so that we can share successes. As one final point. I did want to note that on that inclusion and equity aspect of things, we have other goals and objectives that we're working towards, that we know are barriers, that we know may not actually be happening right now, but that we'd like to see them.

Naomi:

For example, we know that domestic violence and mental health are both things that are really difficult when it comes to our communities, and it comes to ending the HIV epidemic. We need to really address those two things. Our providers may not necessarily be doing mental health screenings, and we may not be doing DV screenings or domestic violence screenings either, but we have identified that those are needs, and those are barriers. And I would like to encourage individuals to, in your areas, find those aspects that aren't being addressed and put them in your integrated plan. That's the point of when we're coming to objectives. The objective is to be able to reach populations and to reach their needs. What are the ways that we're going to do that?

Naomi:

Well, this is the first step. So I really would like to encourage individuals to focus on that inclusion and equity aspect of the SMARTIE goals. But again, thank you so much for having the both of us and Tampa-St. Petersburg says hello from Florida.

Molly:

Thank you so much for such a wonderful presentation, Katie and Naomi. It's so wonderful and kind of exciting to hear all about all the work you're doing and the community engagement and involvement. It's just wonderful work. So thank you. We have time for a few questions. Let's see here, Gretchen, I'm going to go to you first if that's okay. So this was somewhat touched upon, but I think a really important point to really sort of highlight, underscore. So can you describe the difference between goals and objectives? Are they interchangeable, or is one under the other?

Gretchen:

Yeah, so this is where gets to be a tongue twister. And I do almost wish I had a whiteboard or something to draw on, and I know there are those functions in Zoom. But I did include an answer to this in the Q&A box. But to try to repeat what I said is that goals and objectives are technically different things. They have different definitions. And one place to look for that is in the table included in an earlier slide from the National HIV/AIDS Strategy. That being said, with the clarification that CDC and HRSA made in the FAQ document, where they added the "or" statement and put in a slash, so its goals and/or objectives, it really allows for them to be used interchangeably as it best meets what your jurisdiction needs based on how you're setting up the plan.

Gretchen:

And so an example of this is if you are using the NHAS goals as the organizing principles or organizing framework for your plan, since those are already goal statements, you would most likely develop objectives to fall underneath those goal statements. Appendix 2, the template that is provided in the

guidance for this section actually doesn't use the word objective. The template includes goals underneath each of the four focus areas.

Gretchen:

I think that this is one of the clearest indications of where you could use goal or objective interchangeably. You're almost using that focus area as your goal statement. In fact Diagnose has really a goal statement, for example, that is associated with it, as read on an earlier side, it's diagnose all people with HIV as early as possible. So as I said, if you would like to talk through this further, as it relates... Drew, I just saw your thank you. So you're welcome. And I'm happy to talk through this further with you more and kind of play around with it. And I actually also think while I'm off mute, this might be a good time to ask Naomi and Katie a question. If you could share with us how Tampa-St. Petersburg is planning to, or has already decided on structuring the plan, it would be very helpful to hear.

Naomi:

So the way that we've structured our plan is that we are going to follow those four pillars that EHE has. We are making sure that we are still following along when it comes to the way that we had our previous iteration with goals, objective, strategies, and activities, but we found that the four pillars fit our needs and the way that our jurisdiction works the best.

Molly:

Wonderful, thank you. We have a few more minutes. So please, if you have any follow-up questions for anyone, please chat them in. Let me just take a look here. Let's see. I'll throw this one out and see if anyone would be interested in responding. So someone asked should jurisdictions be thinking about including action steps defined for strategies under this section? I wonder if Gretchen or someone, Stewart, would like to sort of expand on this a bit, but the sort of the action pieces, the steps of doing the work of implementing the goals and objectives.

Gretchen:

Yeah, absolutely. So this is called the Goals and Objectives section, but what I would really just point everyone to again, is that an important point. I'm glad actually, that this question was asked, it allows me to make an important point, is that Appendix 2 is given as a sample template. But it is noted that if you don't use that template exactly as it is, all of the required information that's noted in that template is still required for you to include however you end up organizing your Goals and Objectives section. But the specific points that are being asked for, the key activities, the resources, the partners you'll work with, that should all still be addressed. So absolutely, you want to use and detail, really take some time to detail the activities and strategies that you will undertake, that you will implement to achieve your objectives and your goals.

Molly:

Great. Thanks, Gretchen. Just taking a look here, we have an interesting question that came in, and I actually would like to put it to you all who are here participating in this webinar. So someone asked, has anyone been successful in engaging non-Ryan white providers in the integrated plan or EHE work? So if you wanted to chat in anything you would have to share around that, I know that the person who asked that question would be very grateful. I also would take a moment here to also plug the peer learning

session that we are having next Tuesday. Let me just confirm that's the correct date, I believe. Yes, next Tuesday at 3:00... We can come back to questions, but Travis, do you want to go to the next slide?

Molly:

So we have the peer learning session next Tuesday at 3:00 PM Eastern time. And during this session, it's moderated by the IHAB Tech team, Gretchen will moderate it, but it's a really sort of loosely structured hour for you all to come and ask those wonderful questions and to hear. Everyone is off mute, you can share your video. And it's a time and space for you all to come ask questions, share information, discuss sort of emerging challenges that you are experiencing, and sort of brainstorm with your colleagues, ways to address those.

Molly:

And so we will chat out. Thanks, [Chivey 00:55:18]. Chivey just sent out in the chat, a link to register for the session. You will not have needed to attend this webinar in order to participate next week. But we do ask that you come ready to engage in conversation and share your ideas, thoughts, questions. We also ask that federal staff respectfully, are asked not to attend. And so it really is sort of a place for you all to come and really connect with your peers. Let's see. So I'm just heading back to the Q&A.

Gretchen:

Hey Molly, I've got another question that we can answer from the Q&A box. This one is from Karen, and it gets to the number of goals and/or objectives. And I do want to point out that in the guidance document, and this was also what was then brought up in the FAQ document, there is one numeric requirement here, which is that there should be at least three goals and/or objectives for each of these four areas.

Gretchen:

So we've already addressed this issue with the fact that goals and objectives can be two separate things. They can be used interchangeably. But for each area under, I'll use Diagnose as an example. So under Diagnose, it should be very clear that you've got three goals, three objectives, or whatever terminology you are using, at least three things that you are doing associated with that focus area. I do here, really want to emphasize that this is probably a little bit neater to count to three when you are using the EHE strategies or these four focus areas as how you are organizing your plan.

Gretchen:

So if you follow Appendix 2, it's sort of much neater to see 1, 2, 3, 1, 2, 3, maybe 1, 2, 3, 4, 5 under each one of those areas. But that is not to say that you can't clearly show that you've achieved this requirement of at least three if you use another format. So in that second example that I provided in the slides presented earlier, it was of a jurisdiction that shows to use the NHAS goals and include objectives under the NHAS goals.

Gretchen:

In this case, you would have at least three objectives. No, I'm sorry. NHAS goal, objectives underneath the goal. And you would want to label each objective as being aligned with one of the pillars. So you could again go through and count and say, okay, we've got three that are associated with Diagnose,

three that are associated with Treat, at least three associated with Respond, et cetera. So hopefully for everyone, that didn't make it more confusing again. Please reach out to us directly at [ihabpack@jsi.com 00:58:49] if you want to go through this individually, but that requirement of three is in there.

Molly:

Great, thank you, Gretchen. So we are coming to our time. So I'm going to sort of transition us. I know that we didn't get a few questions answered, so we will do our best to follow up again, with anyone who has outstanding questions. Or of course, we'll show you at the end, our email address and website. You can reach out to us if there's anything that we can help you with.

Molly:

We do have... Thanks, Travis. So the new tool that we have been so excited to be promoting is our, our HIV prevention care and treatment resource inventory compiler. This is now live and available on our website. And this tool was featured I think, two webinars ago. But again, this tool has the capability to capture information needed for the Resource Inventory section of the integrated plan. You can create a table and export it in PDF form, and you can also analyze the data with a number of pre-programmed options. So my colleague, Shaivi just chatted a link to that in the chat. We strongly encourage you to check that out. And again, please do get in touch if there's anything we can do to help support you all in using the tool.

Molly:

And then as always as a, we've been saying throughout, please don't hesitate to get in touch. If there's anything we can do to help, our email address is Ihabtech@jsi.com if you have any follow-up questions today, or any help with the resource inventory, the compiler tool. Our website is targethiv.org/ihab. You can find there, recordings of all the previous webinars that we posted, as well as information for upcoming events. Continuing with this series, we have a few more webinars sort of in the works. So look out for information there that you can register for.

Molly:

And then you can also access our online course and introduction to HIV prevention and care planning. I believe Shaivi chatted that out at the top of the webinar today, but this is a great sort of self-paced online course, especially if you are new to integrated planning or new to health planning. This is a wonderful way to get a sense of sort of the landscape of what we're doing, sort of why we're doing this, the sort of history context, and then some tips for getting going on integrated planning.

Molly:

So with that, I just want to thank everyone for joining us today. Please stay on and take the evaluation that's going to pop up when the webinar closes. It really helps us get a sense of what we can be doing differently or better to help meet your needs. And so we appreciate you taking the time to do that. And as always, thank you for joining us, and have a great afternoon.