IHAP TAC Peer Panel Transcript
Your Integrated Plan is Submitted – Now What?

Travis: So today, we'd like to welcome you to our new peer panel sessions, where you get to hear from your peers. These will be bimonthly sessions with a panel of jurisdictional peers. We have three different jurisdictions today.

We'll focus on a different integrated planning topic every session, and you'll see IHAP TAC staff like Alexandra and I facilitating the discussion on that topic. We'd also like to be able to address emerging and ongoing questions that people have, and of course, promote peer engagement and learning. You can find more information about our peer panel sessions at targethiv.org/ihap. Next slide.

And then for today's agenda, we'll next have a welcome from HRSA HIV-AIDS Bureau. Then we'll go over our objectives and then we'll jump into the main part of our session today, which is an overview of the integrated planning process having our jurisdictions... I'm sorry, actually this is just a brief introduction here where we'll talk about where we are now in terms of implementation, monitoring, and ongoing stakeholder engagement.

We'll introduce our panelists to you and then we'll have the meat of the discussion where they talk about the implementation, monitoring, and ongoing stakeholder engagement. We'll then address your questions and answers, and we will then also ask you to do an evaluation. Next slide.

So for our next slide, I'd like to welcome Dr. Susan Robilotto, who is the director of the Division of State HIV-AIDS programs at HRSA's HIV AIDS Bureau. Dr. Robilotto?

Dr. Susan Robilotto: Thank you, Travis. Hello, everyone. I am happy to be with you today to welcome you to this peer-to-peer discussion, but also to provide a couple of updates on behalf of HRSA and CDC on the integrated planning review process. First, we want to thank you for your work in submitting your plans.

As you know, integrated planning plays a critical role in identifying, measuring, analyzing, and monitoring activities and information to inform decision making and improve HIV prevention, care, and treatment efforts within your jurisdictions. It is no easy task, but rest assured that the IHAP TAC team is available to support you. We wanted to let you know what you can expect in the next couple of months as CDC and HRSA are currently jointly reviewing the submitted integrated HIV prevention and care plans for legislative and programmatic requirements.

After the joint review has concluded, project officers will provide feedback through cover letter and summary statements to each of you. Additional information will be shared with recipients in coming weeks. Should you have any questions or concerns regarding your integrated plan, please do not hesitate to contact your CDC and/or HRSA project officers. Thank you for all the work that you do day in and day out to help move the needle on ending the HIV epidemic. Travis, I'll turn it back to you.

Travis: Thank you, and I'll turn it over to Alexandra.

Alexandra: Thank you so much. So for today's objectives, we are aiming to accomplish these three and by the end of this peer panel session, participants will be able to identify at least one activity or approach to support successful integrated plan implementation, describe at least two approaches for ongoing stakeholder engagement and communication of integrated planning progress, and describe at least one approach for monitoring integrated plan activity to ensure goals and objectives are met.

We have included this figure in our webinars as an important reminder that the integrated planning process process is not just the 18-month plan development period. The focus of today's webinar is on these future faces, the ones that you see with the arrows, the implementation, monitoring, and sharing progress, and how the jurisdictions are currently planning to undertake them.

An important detail for this webinar is listening from our peer panel on their learning experiences and plans to support successful integrated plan implementation, ongoing stakeholder engagement, and communication of the integrated plan progress for monitoring the integrated plan activity to ensure goals and objectives are met. We've heard from many of you that your jurisdiction was focused on developing a truly actionable plan. You don't want something that sits on your shelf, right? So this is important to think about during the implementation of your plan.

Next slide. Now let's meet our peer panelists. So first, we have Holly Hanson. She is the Ryan White Part B program manager for the state of Iowa. She is responsible for ensuring program compliance with the Ryan White Treatment Extension Act, including strategic planning, reporting requirements, grant and budget management, program implementation, and communication. She has been in this position for over 21 years and Ms. Hanson received her Bachelor of Arts in Social Work from the University of Iowa and her Master's of Arts in Counseling, Psychology, and Counselor Education from the University of Colorado at Denver. Welcome, Holly.

Travis: Next we have Isabel Evans, who is the Ending the Epidemics program manager in the Office of HIV and Hepatitis C services at the State Health Department in Arizona. In this role, she manages special projects, planning efforts, and training and workforce development for statewide HIV and Hep C programs.

Prior to her work in Arizona, she worked on local opioid overdose prevention programming. She received her BA in Public Health studies from Johns Hopkins University and her Master's of Science in Public Health from the London School of Hygiene and Tropical Medicine. Welcome, Isabel.

Alexandra: Now we have Deborah Reardon-Maynard, and she is the program improvement manager for the HIV prevention program at Arizona Department of Health

Services in Phoenix. In this role, she supports statewide planning efforts and works with programs implementing targeted of behavioral interventions and condom distribution as well as capacity building.

She received her Bachelor's degree in Sociology and Community Health Education with a focus on Sexual Health from Northern Arizona University, and her MPH with an emphasis in health education from University of Arizona. Welcome, Deborah.

Travis: Next, we have Joana Mendez, who is the HIV Integrated Planning Liaison on the Integrated Plan Team at the Arizona Department of Health. Currently in this role, she engages statewide stakeholders, analyzes data, leads communication efforts, and evaluates programmatic processes. She uses her social work training and previous manager role at a shelter for men experiencing homelessness to bring a social justice approach to the work she does. Welcome, Joanna.

Alexandra: And last but not least, we have Carmi Washington Flood. Has been, Carmi, in the field of public health for more than 40 years. She works across the spectrum of service delivery to address the needs of vulnerable communities in Maryland. In her role as the chief of the Office of Faith-Based and Community Partnerships within the Maryland Department of Health, she serves to connect faith and community-based organizations to expertise and resources that will build capacity for holistic health and wellness.

Welcome, Carmi, and thank you all for being here today. And now, let's hear from our panelists. Next slide please. First up, we would like to hear from all of you, the first question that will be opening our discussion today will be what approaches or frameworks did your jurisdiction use to structure your integrated plan? And first up, we would like to hear if ready from Baltimore.

Carmi Washingto...: Well, thank you so much Alexandra and Travis. It is good to be here in this space knowing that Maryland is playing a vital role in sharing the information and strategies that we use in developing our integrated plan and in submitting it on time, which I know is a major goal for everybody in this room today.

In Maryland, and I was very glad to hear you say as you looked at that diagram around the timing of developing a plan, that 18 months is so critical to the process, in Maryland, we took a full 15 months prior to the due date of the integrated plan, starting with biweekly meetings in October of 2021. We termed those meetings community engagement live listening sessions, or in short CELLS. We had those meetings every other week for 90 minutes per meeting, and they also encompassed our quarterly meetings. We did that session.

Then we also had a session in the spring where we engaged a community leadership in person session of just faith leaders from around the state to come. These meetings allowed us to determine key themes across all of our pillars and

key themes within each of our pillars. We leaned into the pillars, the strategy that was identified for ending the epidemic, HIV epidemic.

In that framework of diagnose, prevent, treat, and respond, we laid a foundation of health equity under an umbrella of holistic wellness. Approximately three months before the integrated plan was actually due, we further engaged our HPG members/invested stakeholders in three immediate ways. We began meetings that we call SWEETS, stakeholder, wisdom, experience, and engagement tactical sessions, because we wanted to move from just discussions around what were the issues and concerns and what we prioritized or envisioned happening to how would we go about making those things actually happen?

We transitioned from those SWEET sessions to what we called our review, reflect, and revise, or our RRR meetings. Every single stage of these biweekly meetings had a definitive focus and a lens for us to approach the conversations and people continued to show up, every two weeks. We facilitated the group's working knowledge of the federal core requirements for our department by disseminating copies of the entire integrated HIV prevention and care service plan guidance, so our membership and our stakeholders would know what we were required to actually put in the plan and how well we could work with that.

And then we purposely discussed and demonstrated the relationship between the national HIV plan and the Ending the HIV Epidemic plan, so that people could see how those actually met and were aligned with what we were doing moving forward. We highlighted what our cross-pillar themes were for individuals and then began to work from that point in a very deliberate and intentional fashion with these ongoing conversations. I'm going to stop there and pass the baton on over.

Alexandra: Thank you so much, Carmi. That was a wonderful illustration and explanation. You can almost picture the process in your head, the way you explain it so clearly. I know Iowa had a similar experience. I will pass it to you to see if you could share. You want to share?

Holly Hanson: Yeah, thank you. I am also very happy to be here. So, we did do something similar. We definitely planned for longer than 12 months. I'm looking at our structure and timeline here. And we really were planning for 18 months. We are a low-incidence state, so we weren't one of the EHE jurisdictions, but prior to COVID, we were planning on developing an Ending the HIV Epidemic plan and got started on that, and then stopped everything because of COVID and put everything on pause.

And then when we were about ready to pick that up, the integrated plan guidance came out. So we just did those two things together and we divided it into three steps. So step one was to review and confirm structure. So as it was

said in my introduction, I've been doing this for a while, so I've been part of many, many planning structures.

So we always learn something from before and try and improve upon that. And we really wanted to get more community input across the state. Certainly our community planning group or CPG was an integral part of our planning process. They always have been. But we wanted to go beyond CPG for those folks that for example, used to be on CPG, but they're really back engaged in a working environment and can't make it.

So we wanted to travel more. So we spent the first six months really developing the structure and the structure that we chose was to categorize things in eight key focus areas. So, we had our regular focus areas like primary prevention and testing and things like that, medical and support services. But we wanted to make sure that we integrated coinfections or as endemic approach with STI and Hepatitis.

We also had a social determinants of health focus area, health equity focus area, behavioral health and workforce focus area. Each of those focus areas were assigned a department co-chair, a community co-chair, and an agency co-chair. So there'd be three co-chairs. And then that group would then decide how they were going to get input as to what would it take to end the epidemic in this particular way.

And some of those sessions, we did them together. So for example, behavioral health might have gone with medical and support services, and we did do that. So we did regional meetings, we did focus groups, we did key informant interviews and so on and so forth. That was our information gathering stage, and then we came back and put that all together, and that took a while. And unlike Maryland, we did not get ours planned on time and submitted in time, but a month later, we got permission to turn it in a little bit later.

We are a small state with a small staff, so we were really excited with all the information and a lot of innovative approaches that were being suggested to us. So we wanted to take the time to make sure that we got that all in there. And we did structure the plan much like the national HIV-AIDS strategy with the four overarching goals.

We really modeled a lot of what we're doing and will be doing after the national strategy and their corresponding implementation plan. So I think with that, I'll go ahead and pause with-

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Holly Hanson: So I think with that, I'll go ahead and pause with what we did to put our plan together.

Alexandra: Thank you so much, Holly, for sharing. It seems that it's very comprehensive, so it's worth the time of planning, including all the approaches, and all the themes and topics there. So thank you. We'll now go ahead and pass it to Arizona. I know Isab wanted to share some of their frameworks and approach. It's around this endemic plan in HIV, Hepatitis, STI?

Isabel Evans: Yeah, absolutely. Thank you so much. Hi, my name is Isabel Evans, and I use she/her pronouns. I'm here at the Arizona Department of Health Services. There's actually three of us here today. So you get three of us here from Arizona providing slightly different interpretations of a few things. But the three of us worked really closely together on this project, as what we referred to as our integrated planning team over the past about two years. Similar to what Carmi and Holly have mentioned, we also started this a long, long time ago. We began in early 2021, getting our feet wet on our needs' assessment, making sure that our statewide surveys and focus groups went out. I really will echo what Holly said about getting folks involved who had not previously been involved, and we really started off with our surveys and focus groups to make sure we were doing that.

One of the interesting parts, here in Arizona, that's a little different, is we actually did take a fully syndemic approach to our integrated plan. So we included STIs and hepatitis C as full-fledged members of our plan. So it was an HIV, STI, Hep C integrated plan. It made things a lot more interesting, and a little bit more complicated, but we do think it was worth it in the end. And for us, although we had a lot of status neutral pieces, it was not technically a status neutral plan, because we did use the EHE pillars. So we felt that the EHE pillars of diagnose, treat, prevent, and respond mapped really, really well onto STIs and Hepatitis C.

Additionally, our STI and hepatitis C programs, at the time, were within the same office as our HIV programs, felt like the pillars were also applicable to them. So we said, "Hey, we're going to do this integrative plan. We're thinking about using these pillars of diagnose, prevent, treat, and respond. Does that work for your programs and your funding streams?" And they basically said yes. So we went ahead and used the EHE pillars, but we did do an appendix as part of our integrated plan. They did a crosswalk between the National HIV/AIDS Strategy goals and metrics, and our pillar goals and metrics from our plan.

So although we weren't using NHAS, technically, we were going back consistently, making sure we were checking the boxes on the National HIV/AIDS Strategy goals, and also ensuring that all the NHAS major outcomes, that are listed in that NHAS large plan, were included in our overall metrics and outcomes in our pillar plan, to ensure a little bit of consistency there, and make things easier for ourselves in the long run as well.

One of the other pieces here in Arizona, we do have a Ryan White Part A. We have one here in the middle of the state that covers Phoenix, including two of

our counties. That does cover about 60 to 70% of our population here. So as you can imagine, we work very closely with them, here at the state health department, to ensure that we're keeping our county partners and that Part A office aligned. So although our state health department was managing the integrated planning process, we did do a joint plan for our whole state. So that was not only our Part A here in Phoenix, but also a Part A up in Las Vegas that covers one of our northwest counties, along with our Hepatitis C planning body, our fast track city here in Phoenix and our STI partners.

So we had a lot of people in the room, and one of the things that this meant was that we couldn't use our typical structures. We have an amazing Statewide Advisory Group for HIV prevention, and HIV care, here at the state level, and we have an incredible planning council for our Part A here in the Phoenix area. Our Statewide Advisory Group, also known as SWAG, was really involved in writing our Ending the HIV Epidemic plan across 2020. They were very involved in sort of the day-to-day work of getting that EHE plan written, but we realized that if we were going to include STIs, and Hep C, and more Part A folks, it just didn't make sense to put all of the burden on our Statewide Advisory Group to write the integrated plan.

Therefore, we did presentations and ongoing meetings with a lot of planning bodies throughout the state, since I think we kicked off in about August of 2021, with a couple of earlier meetings with co-chairs and leaders. But we met at planning bodies. We provided updates, but we decided to create a few new structures as well, to ensure that our structures were fully integrated. We developed an oversight committee that included members of all of the programs that needed to be represented in the integrated plan. For those of you who worked on a plan, you know what I'm talking about in that long checklist and one of the appendices of everyone that needed to be involved. Basically, we took that list, found someone that met all of those criteria. We made an oversight committee that met every three to four months to make sure that we had the folks in the room who needed to approve the plan, engaged from the beginning.

We kept those meetings short and sweet, and not very frequent, because those were really busy folks. However, we also needed some folks who were a little more willing to provide more time and energy. So we developed pillar level work groups with four to six folks across HIV, Hep C, and STI, typically folks who are working frontline in the field at agencies. And they met with us more frequently, typically every other month, to work on actually drafting the plan, going through ideas and strategies, figuring out our metrics, and then we also met very frequently with our internal teams.

So although I would definitely highlight what Holly and Carmi said about starting really early, and getting folks engaged, because we took this syndemic approach, and we took an approach where we were trying to align our integrated plan with our EHE plan, our Fast Track Cities plan, and our state's

Hepatitis C Elimination Plan, which was being written throughout 2022 and was actually just published a few weeks ago. We're really excited about it. We needed to create some new structures, some new frameworks, and some new approaches, in order to ensure that our plan was actually integrated, and not just giving lip service to our STI and Hep C team, since we were putting their names on the front cover of this plan.

We found that it worked really well. It was really great. I know that we have a question later about lessons learned, so I'll let someone else from my team talk a little bit more later on about what we learned, from trying out new structures and a syndemic approach, here in Arizona for the very first time. I'm going to turn it back to our facilitators to keep us moving and grooving.

Alexandra: Thank you so much, Isabel, for sharing your experience in Arizona. I just wanted to remind everyone that even though you're in listening mode, the participants, I see you've been using the Q&A box, the question and answer box, so feel free to drop in your questions. We will be addressing those towards the end. So Baltimore, Iowa, and Arizona, thank you so much for sharing your experiences in this first round, and now I'll pass it to Travis.

Travis: Great, thank you, Alexandra. So we just finished talking about writing your plans, and all the work that went into planning that all out, doing assessments, getting groups of people together. Now we definitely want to move on and start talking about the most important stage after all of that, and that's implementation of your integrated plan. So in this next series, our panel will discuss what their next steps are for integrated planning implementation, including things like talking about the roles of different people, different agencies, organizations. How they've come about creating a work plan, and how have they delegated out those different planning functions. So this time around, I'd like to start with Holly in Iowa.

Holly Hanson: Yeah, all right. Thank you, Travis. So because we cast such a wider net this time, when we started thinking about implementation, we decided, because there were certain things that we could go pretty deep into how we're going to implement this, and then sometimes we couldn't go that deep because we didn't have all the right people at the table at that time. And so what we really did with our messaging, when we were putting all of these ideas together from the focus groups, the regional meetings, the surveys, and so on and so forth, we really kept it to a structure, much like what the National Strategy has, with those four overarching goals, some key objectives underneath those, and some key strategies underneath those.

Just putting all of that together was quite a process. It was a very collaborative process, and some of the suggestions that came in were really like, "Those are actually activities, and let's save that for implementation planning." And so it was really handy that the National Strategy also released their implementation plan around the time we were putting all this together, so that we could narrow

our scope, so we could be a little more solid in that scope. And we are currently in the middle of now prioritizing those on which ones do we really want to tackle first, which ones are we already tackling. And then really be clear about what activities we'll be doing around those, and when will we be doing those. And so we're really putting groups together where it makes sense. Some of those are really self-explanatory. If my Ryan White Part B team is already doing something like that, then they're going to be taking the lead on that.

Some of them are new, and so what we've decided to do is over the course of the next six months or so, we're going to hold three summits. The first summit is going to be around stigma. So what we're imagining is a whole day devoted to, "How do we address stigma?" And asking all the questions just around stigma, from where are we now, where do we want to be, and what are the activities? We've already gotten some of them. We've already got some suggestions to really get there. The other summit that we're going to do is around workforce. We did a deeper dive into workforce than we ever have. There's a lot of changes with COVID, a lot of turnover. We really want a healthy workforce, anticipated shortages, and stuff like that. I could go on. So we're going to do this same kind of summit for workforce. And then finally, one of the themes that we heard throughout is really increasing that meaningful involvement of people living with HIV, and other folks as part of whether it be STI, or Hepatitis, and coinfected with HIV.

So we're going to spend quite a bit of time really kind of examining how we're doing meaningful engagement. Now, are we doing that? How can we do better? So those are kind of our big activities that we're planning for the next six to eight months. So just we understand this is an integrated plan for the next five years, but it's also our Ending the HIV Epidemic. So there's going to be a lot of things that we can't get done if you're one or two that will do some more long-term planning around that.

So that's really all to say that, yes, we're going to assign some specific committees, and groups, and folks, but it's not done yet. We're in the middle of that right now. And ideally, we would have some sort of document that we would be able to release at the end of this year. The other thing that I will say about implementation, that we took out of the national handbook, is we were really pleased to see that some quality of life indicators were added. And we adapted, or adopted, those to figure out, "How could we do that in Iowa? Are we able to get baseline in a certain quality of life? Housing, for example. Or do we still need to create something to do that?

And so we've picked about five of those. So we're really excited to do that. We're beefing up our data and quality management programs within the bureau, as well as Ryan White. So that's going to really help monitor that, the data to action, as far as doing some more creative things around behavioral health, health equity, and stuff like that. So I will pause there, and pass it off to my colleagues, I believe, in Arizona.

Travis: Great. Thank you, Holly. I really appreciate you mentioning, just breaking it down into little tinier pieces over time, instead of trying to approach and take care of the whole plan all at once. You do have a five-year plan. Some of it's going to happen right away, or is already happening, and some of it'll take some time to develop that infrastructure, so very good. Learning a lesson that I know, Iowa has had a lot of experiences with integrated plans over the years to learn that lesson. And yes, next we will take it to Deborah in Arizona.

Dr. Susan Robil...: Good afternoon everyone. Thank you. Sorry, I was getting messages on my screen. So our next steps for the implementation here in Arizona. First, we are giving our planning bodies a breather. They've been doing two years of planning, and a year doing EHE planning before that. So they're a little tired. They've been working hard, so giving them a little bit of a breather. And then, while at the health department, so in the background, while we wait for those approvals to come through from CDC and HRSA, we're working on putting a number of tools and documents in place, so that when we put the integrated plan out into the public, and make it available for people to use, that it's really in nice, digestible processes, and ways for them to get that information.

So the first thing that we did, I know Isabel talked a lot about what our process was, and how many folks were involved, but what we found as we went through the creation of the plan is there was a lot of information that came up, that maybe didn't get into the plan, because it was an activity level or implementation level. And so we're in the process of building a companion doc that will go along with our integrated plan so that as folks are implementing processes, as we're putting programs in place, we have all of that additional information that folks can access. We can go back and see what did our community really think about this particular area.

When we said implementation, what were things that were important, what were things that we wanted to make sure that we didn't lose? So we're working on putting that together, and that'll be available not only to our programs at the state, with the federal funding who put out grants and programs, but also to other programs within the state as they do their own implementation of things that go along with our integrated plan. We're putting together a webpage, where all of that information will be available. We do have it currently, and we utilized it during the whole process, but making sure that it's more up-to-date, that all of these finalized documents are there, that we have some easy ways to get that information out.

Working on the, we'd say PDF, but really it's the pretty version. It's the piece that we can publish, and give to folks, or that they can pull down from the webpage. And that has really the important parts, the goals, the objectives, the strategies, the where to get other information. And they don't have to look at the whole hundred pages of our plan that we submitted. Because a lot of that, folks, as they're trying to implement, maybe don't want all of it. So we wanted to make sure that there was a good way for them to get what was important.

And then within our office, because our STI, our Hepatitis C, our HIV programs, are all together. So within those offices we're doing strategic planning, which is not because of the integrated plan, but it's nicely timed. So that we can really use our integrated plan to make sure that as we do the strategic planning, we're keeping things aligned and we're making sure that not only do we not make our programs sad by what's in the integrated plan, or by what they plan to do, and we come back and say, "Hey, we need this," but just making sure that everything aligns, and we're all kind of moving forward with the same goals.

And then we are also using our plan to put together programs. As we come up with times where we're going to be putting out new funding into the community, we're writing grants, and RGAs, and all of those fun things, we want to make sure that we have that plan available, and that we're all moving along with the plan, so that we're doing the things we said we wanted to do. So utilizing that, sharing it with our partners, just keeping in line. Let's see, some other... We do have some specific roles at the health department that will be overseeing implementation. I mean, you're meeting most of us right now. So our IP plan will still be heavily involved. And we've created a new office within our program. Or a new program within our office, I should say, which is the end of the epidemics team.

And on that team there is a staff person who handles things like planning. So working with our Statewide Advisory Group and the other planning bodies, but doing all of that ongoing planning, but also making sure that those groups are involved with the integrated plan. And then there's also an epidemiologist on that team who will be monitoring the metrics and the objectives that are in the plan, and making sure that we are able to get that information back out, and tell people about progress and how we're doing as we move along. So handling those data projects and not tracking. We have not created a implementation work plan as yet. We're in the process of that. We do want to have that work plan, and we want to use it to make sure that our office-wide priorities are all staying in line, that our strategic planning is in line. And that with upcoming funding decisions, that everything moves along.

So we are building that specific work plan as we do the strategic planning within our office. And as we look at what our new funding opportunities are going to be from CDC, from HRSA, our Hep C folks, I'm just making sure that we're all in line. And then, as far as our planning bodies, we do have our Statewide Advisory Group. And we didn't do a specific committee, and say, "You're going to be in charge of this." What we're doing is keeping our entire planning body apprised of all the progress, all the updates, making sure that they're involved in figuring out how much of their time is put into this integrated plan. How often do they want to look at information, and then making sure that there's a whole system in place for them to get those progress reports back, and do those yearly evaluation, and do updates. Additionally, we'll be building a small integrated planning council.

Like we said earlier, we didn't want to put everything on our Statewide Advisory Group for HIV, because we want to include Hep C and STI as well. We have all those pieces in there. So we will create a small integrated planning council that will be made up of a few folks from each of those areas, a few from STI, a few from Hep C, a few from HIV, and including our planning bodies in that. And that's the group that will help us with the day-to-day, meeting more often only about the integrated plan. So that we can make sure that we're tracking and utilizing it in ways that work for the community, and that keep everything aligned with the plans that we have. I think I'll pause there, and hand it back to you.

Travis: Okay, thank you. I really appreciate you talking about creating some additional documents to help people pull out some of the pieces that they might be more interested in in the plan. I know that with the National HIV/AIDS Strategy, that's something that we've looked at. In the [inaudible 00:43:55], is that they have a fact sheet that's a one or two pager, just brief overview. And then they also pulled out a different document, where they just have the goals and objectives. So it's a really good idea for states jurisdictions to do, with your integrated plan, so that you have a couple different versions of the document. Or the overall outline of the document so that people can look at it in different ways.

And it also sounds like you all just have a lot of really... But I heard that from both Iowa and Arizona, as you have some ways that you're really thinking about using this plan to do things like quality improvement, putting it into grants and contract and things, for example. So just really making sure that it's a living document. That's great. All right, and to wrap up this section, we'll get back to Carmi in Baltimore.

Carmi Washingto...: Yes, thank you so much, Travis. And I am going to jump right in with your last phrase that you used, about the integrated plan being a living document. That was one of the things that our Pure director stress the entire time we were in the planning phases and stages, and has bought that also into our new process, with the implementation of the plan itself. Immediately after our submission of the plan, we wanted to make sure, and did make sure, that the plan itself, the full document, got into the hands of all of our HPG members, and the more than 350 stakeholders, who were part of a regular invitational list, to the meetings that we have been engaged in, had that plan directly. That they were able to see what the cross pillar themes were, or priorities were, that they were able to see what the priorities were under each of those pillars that were identified, as well as the foundation.

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Carmi Washingto...: Pillars that were identified, as well as the foundational pillar of health equity, and then our overarching umbrella of holistic wellness. We wanted people to see that. We did give a slight break in those biweekly meetings. So right after the plan was submitted, we gave people around a four to six week break. But

then right at the end of January 2023, we started back up with our biweekly meetings and we renamed the meetings to CORE meetings. That stands for Community Operational Response and Engagement, Community Operational Response and Engagement. And as you all can see, we are big on creating acronyms, but also with the lens of what is happening now, because we wanted the community to know we're coming back to operationalize now what has been identified as our responses. And with the mindset that there is this huge product that we are now working towards, not just the vision, but actually putting into practice policies and programs.

And the only way to make that happen is to continue to have these bite size engagements through these biweekly meetings. The beauty of who is at the table, we need to look at what are the roles that are overseeing the implementation at the table every other week. Every other week is our bureau director, and the director has not missed any of those meetings since the time we have been engaged. Even if he had to step outside for a portion would always be there to open and engage our leadership with all of our centers and offices, our epicenter, our STI center, our harm reduction folks, our viral hepatitis individuals, all of those people have been at the table and have had representation from their various units. Our AIDS Drug Assistance Program, they have been at the table, which has helped us in the conversations for people to realize you don't come in, share information, and then that information has to be taken back and then rediscussed and then decisions made with folks who were not in real time at the meeting.

So these biweekly sessions are critical as they go on. As we came back into the CORE meetings, we utilized the very first six sessions of those meetings for people to further understand what the federal requirements were of each of our centers and offices. So for instance, what is required when it comes to data collection and data management, data publication, data upkeep? So we had our Center for HIV Surveillance, Epidemiology and Evaluation come in and share that, what is required of our ending the HIV Epidemic Director? And she is even in this space right now. And her entire team, what is required of them federally to produce and promote and to report on throughout the course of the year in relation to that dynamic and what is required in the plan, what is required from our HIV Prevention and Health Services programs, how is all of that brought together and then having that presented?

What is required within our STI programming? And having the entire group come together and hear from each of those centers and offices, what the Feds require in the demonstration of good programming and good policy, good practices going out and how those actually align with some of the priorities that have been created for the new plan. And where there are areas that we need to beef up programs as well as beef up opportunities for new programs to happen. We are in the process right now of doing what our director calls, "Identifying what the deliverables will be." So while there are specific priorities that were highlighted in our plan, priorities around connecting people to services,

priorities across education, priorities dealing with community engagement, and then priorities identifying and addressing system barriers. As we look at those priorities, what are the deliverables within each of those that we want to achieve, again in bite-size portions.

So what do we want to achieve in the next 12 months? We are in that process now of having those discussions and as we plan those, we will line those up and then develop the metrics around them so that we know how to measure as we're going forward. Now, the beauty for us, our data people have been in these meetings every step of the way. We have secured data from across our bureau in all the centers addressing each area separately and collectively, so that we are looking at a no wrong door process and an area of its status neutral approach to addressing this very specific syndemic of concern that is HIV, STIs, adult viral hepatitis. And for us as well also harm reduction services as we are moving forward. Everybody is at the table, and everybody is constantly in these communications that we are having with our group.

We actually have a quarterly meeting that is coming up tomorrow where we're going to walk back, and again highlight what the goals and priorities are and then dive a little deeper. And that's what we use these biweekly meetings for. We are continuing the process. We have an entire schedule. And some people looked at it and said, "Oh my goodness, you have biweekly meetings scheduled for the entirety of 2023." And it's like, "Yes." Because if we are really looking at ending the epidemic and looking at the plan of 2030, then we say, "We got seven years to make this happen." And five of those years are part of this critical plan that is moving forward. So back to you Alexandra and Travis.

Travis: Great, thank you so much. Coming from a state health department previously, I love hearing that you have all your different departments coming to the table, sharing information, even talking about what the federal requirements are. I know a lot of people end up in silos in their different departments, and it can really help with that synergy moving forward if you kind of understand what everyone is required to do and see ways that you can collaborate together. So that's a really great lesson for folks to learn. We can move on to the next slide and I'll pass it on to Alexandra.

Alexandra: Thank you so much. A highlight for [inaudible 00:54:01] and the other folks is when you have your meetings already in your calendar, you could actually get everyone on board and on track and you get the rhythm going. So thank you for sharing that. We've heard that you all had different approaches and frameworks to structure your integrated plan, and you've shared your plans, and if not, you've been already during your implementation, but now we would like to move towards the following. How will your jurisdiction monitor the plan and share updates with stakeholders? So when answering this question, we will like for you to think about what is the role of the planning body, if you haven't mentioned it yet, what are your plans for ongoing stakeholder engagement, and

what communication strategies will you use to communicate progress and updates? And first up, we have Arizona. Deborah?

Dr. Susan Robil...: Thank you, Alexandra. So starting with how we're going to monitor the plan, the bonus [inaudible 00:55:15] is that we were able to add an epidemiologist onto our team. And so she'll be focusing on looking at all those metrics that are in our plan and monitoring those, seeing how we're doing, looking at progress, creating some of those tools that will let us give that information back to the community in really useful ways. So we're going to start there. We're also planning to do an evaluation survey each year and really just kind of a simple, we call it a stoplight survey where we're asking the folks that we're involved and are continuing to be involved, "How are we doing? Are things moving forward? Are they not really on target or they are, but maybe they're just kind of stalled? Or is this something that's not happening or shouldn't be happening to give us that ability to really look at the plan every year?"

[inaudible 00:56:09] was saying earlier, "It's got to be that living document." And this is a great way for us to be able to have that be that living document and really look at it every year and see where those changes needed to happen, even if those are changes in language or something where terminology changes. So just making sure that we can do those updates and share those. So our planning body will look at that progress. They'll look at the data that's collected and those metrics. Each year they'll be looking at changes that need to be made to those strategies or to the language that's in the plan, evaluating it each year to see what updates need to be made. So advising us on that. The other big part of that's going to be that IP council that I had talked about earlier where we've got a group of folks whose main job in planning is going to be to keep an eye on the integrated plan.

And so they'll be helping us to also determine what objectives need to be looked at each year. We don't want to try to do a full scale update every year. We would do nothing but that. And so making sure that it's really manageable and we're taking it in pieces that need some help and not trying to do the whole thing. And then our ongoing stakeholder engagement. Besides our swag, we also have our other planning bodies. So our Part A Planning Council, the planning council in Vegas that we work with, our fast track cities, all of those folks will be kept updated about progress. They'll be involved in those surveys. They'll have access to all of the documentation. We will do updates to them every year. But then also having community webinars where folks who maybe aren't involved with a planning body or that don't want to do that full-time, but want to come to a webinar and just hear how it's going, see what's happening at points in time.

So we'll continue doing those webinars, some feedback sessions. We're doing listening sessions with our community and seeing what's changed, what do we need to consider now? But doing that kind of wider dissemination and the input from our folks. And then each year we hold a symposium, which is our HIV, STI,

Hep C. We do all three together. It's a big integrated fund conference, and we will always do a presentation on this so that folks that otherwise aren't involved can come and hear about it there as well.

So giving another way for people to be involved. And we'll have hopefully some great communication strategies. We talked about having the website, so we'll have that where all of our goals, objective strategies, the nice version of the plan, any tools that we have will be there, but also these progress updates. So any of these reports that are created each year, the results of these short surveys, the focus group reports that were created during our integrated planning process, all of that is on that website. And so we'll continue to add to that so that it's an easy place for folks to get information when they need it.

But we also have newsletters. HIV has one, Hep C has one, STI has some different partner communication things, but we use all of those to make sure that updates are always getting out. We'll do our planning body updates, the symposium, our IP council, webinars, contractor updates, basically any way that we can get to our folks that are stakeholders and partners and folks that we want involved to make sure that we can get that information to them. And I think we'll hear a little bit later that a lot of this came from what folks were asking for and how to get that information. So really just trying to look at, "How can we most broadly get that information out there?" And Travis, I will stop now and hand it back to Alexandra.

Alexandra: Thank you so much, Deborah for sharing. Now we will have Baltimore share their strategies for ongoing stakeholder engagement and communication. [inaudible 01:00:25]?

Carmi Washingto...: Thank you so much. Yes. On ongoing is the word. Ongoing is the key phrase, and it is our key activity because one of the things that we found is having these consistent meetings is vital to our engagement and our response and knowing what our responsibilities are. We envisioning monitoring and evaluation to occur actually in real time with real leaders who come to the table with real consumers who are also vested in this process. And real program managers. The beauty of bringing all of these people to the table, and I will tell you one of the things that we do that sometimes people think, they say, "Oh, you use a lot of time at the front of the meeting." But at every single meeting that we have, with the exception of our quarterly meetings, we have everybody in the room introduce themselves and identify where they are from and their roles within their agencies and/or in their communities.

Because we want to know people's voice. We want to know who the crowd is that you are representing? We want to know whose lens are you coming there with? And we take literally the first 15 to 18 minutes of every meeting to introduce people, and I'm talking about anywhere from 60 to 70 to 75 people coming in. And the critical point in that is that persons can see that this really has a statewide impact. Number one, that everybody has the chance to come

into the room and their voice count and their voice contribute. And what we have found is it is building greater partnerships across the board and across the spectrum because now people are recognizing folks as they come in the room, they know, here's where I can find a resource moving forward. Here's someone who is right in my area.

Here's someone who is also addressing some of the same concerns I am. So monitoring evaluation is going to occur in real time with these real people that show up. You can put a name with a face, you can put an agency with a face and a name and have that contact going on. We plan to continue these biweekly meetings. There is nothing in our frame that says they are not working. And other folks are amazed at how many people continue to show up over and over and over again across the spectrum. Again, of all of the concerns that our bureau has across HIV, STIs, viral hepatitis, Community Health and Wellness, across everything, whether it's MADAP services or Harm Reduction services, folks continue to show up and that we have times when folks say, "I didn't know what DIS did. I didn't know what Disease Intervention Specialists did."

"I didn't know what community health nursing was all about. I didn't know what migrant clinicians were involved in." And just all on the spectrum. "I didn't know that there were resources within Department of Education or all of these different places." So it's important that folks show up. So we're going to continue that, and we're going to continue using it as a working dialogue for this living document that we are looking at. We do plan to create space within the core sessions for online work groups to gather, discuss, and then report back how they are looking at the various priorities, and the deliverables within those priorities so that we are held accountable and responsible for reporting back on an ongoing basis.

We are sharing out the recordings of the sessions that we do and the immediate follow-up with any documents that come out so that again, people have a chance if I missed this meeting, I still have an opportunity to weigh in on what happened and then get back. We look for people to email us. Our [inaudible 01:04:37] director is so incredible in the work that she does in tapping into the jurisdictions and sharing what is going on from those areas, as well as having those individuals at the table, again on an ongoing basis. So it is vital for these meetings to keep happening for the evaluations to occur. And we're going to measure it out. Our data people are there. We are working this in progress and in process as we walk through. So back to you.

Alexandra: Thank you so much [inaudible 01:05:13] for sharing. And last, but not least we have Iowa.

Holly: Okay. Yeah, so I think a lot of our implementation and how exactly we're going to be doing it is going to be part of what we talk about this year or six months to nine months, and really kind of hammer all of that out and get all of our group assignments put together. I don't think I've mentioned though that we created a

website prior to even planning, and then there's a specific to ending the HIV epidemic. It was created back when we were going to do that before Covid. And so we have been communicating with the community throughout this entire process on that website. It's stophiviowa.org. And so on that website there is a section where you can go and see the different focus areas that we chose, why we chose them.

The current plan is up there. It says draft plan because as you probably all know, there was a page limit for HRSA and CDC. So there's no pretty pictures in there, which we will be adding to help with the readability. But anyway, that's all up there. And CPG has generally been very central and integral to implementation. We utilize that platform for reporting out how things are going, any struggles, successes, that kind of thing. What we have not been doing that we will be starting is to record those presentations. So we never felt comfortable about recording CPG in general, because a lot of people that are there don't want it recorded that they're there.

So what we're going to start doing is recording those report outs or those kinds of things so that we can then put them on the website. Or even something just as simple as sharing with the rest of the staff at the bureau, because we don't want the entire bureau going to our community planning groups. That's overwhelming for the community. But a lot of times we present things there that really we all also need to know and other stakeholders across the state. Iowa's a pretty big state, and there's not going to be enough people that are interested on CPG for a variety of reasons. So that's one thing that we're really excited to do is to get those kinds of things up on the website so that people have access to them a little bit better.

The other thing we are going to do, oh my gosh, it just slipped my mind. I'm sorry. It'll come back to me. So the rest of the things I really have are about lessons learned I think.

Alexandra: We could probably address those during Q&A. There's some questions around that.

Holly: Yeah.

Alexandra: If you feel comfortable with that, Holly?

Holly: Yep. Yeah.

Alexandra: Okay. Thank you so much. It sounds like you've all have been sharing the three major topics of today, and you painted a beautiful picture of how these things are moving along. So now we will open up our Q&A session and I'll pass it to Travis.

PART 3 OF 4 ENDS [01:09:04]

Alexandra: I'll pass it to Travis. We can't hear you, Travis. I could start if you like, while you troubleshoot your audio?

So first off, we've been having a few questions going through the Q and A chat box. We have first here a question that came up when Holly was talking, towards the beginning, I believe it says, "Have you had any history to where some of your planning bodies may not have gotten along with other planning bodies and how did you overcome those challenges?"

Holly: So in Iowa, we did not have a Ryan White Part A, so we never have had separate care planning bodies. When I came in 2001, they had just started to integrate prevention and care planning into the same planning body. I just walked in. I didn't really know much about the HIV way of planning, so I didn't know what I was walking into. I would say in a low incident state, the reason they were doing that is, especially back then, a lot of the same people were doing both prevention and care.

Largely, there's still that a little bit, but now there's a lot more specialized people. So it has evolved over the years and there's always that push-pull on, is there enough prevention planning, is there enough care planning, and so on and so forth. In that respect, I think that for the most part we're a lower incident state, like I said, and so you have the time to build those relationships. So for us, that really hasn't been a huge issue. Little things here and there, but nothing from what I've heard from other states.

Alexandra: Does anyone else want to chime in and react? Carmi?

Carmi Washingto...: Sure. I will use a phrase that our director use. He always says that Maryland is America in miniature, meaning that we cover everything from the mountains to the prairies to the oceans white with foam. So we have very rural areas within our state, and then we have bustling metropolis within our state. We have coastal areas, they're on the seashore, and then the mountains as well. So what we found, as you say Holly, there're individuals who are really working in those areas that are crossing over and they perform many activities and wear many different hats in our rural areas. What we purposely have done is to make space at the table with specific invitation. Prior to COVID, we went out deliberately to areas, and even in the integrated planning sessions we separated and had very special conversations just with some of our smaller jurisdictions or our more rural jurisdictions because everybody literally is trying to end the epidemic.

Whether you receive special funding or designated funding, everyone is working towards ending the epidemic and this pandemic that we are all addressing. Our director made a point to push that notion that everybody has room at the table. So when we were able to move into this virtual space of having these biweekly meetings, what we allowed was to have that constant conversation so that the rural areas' priorities would not be missed or minimized or muted simply because of the lack of ability to travel or the lack of representation, that we just

made it easier for that to happen. Those are the ways that we could avoid having any kind of tug of war, competition, so to speak, at the table.

Alexandra: Thank you so much for sharing.

Travis: Can you hear me now?

Alexandra: Good. Yes, Charles.

Travis: Okay, sorry. I think I leaned on my little button here. I know it recognized the person where that came from or at least the jurisdiction. I think part of the issue there has been they have EHE planning groups that have formed and then you have your integrated plan group, which could be separate. Might be some mixing over, but I have heard a little bit in some jurisdictions they feel like you have to decide between either EHE planning or your integrated planning group. So I think that's where that question is coming from. Has anyone had experiences with that where it's challenging to get people to do, I know not everyone has EHE funding, but where it's challenging to do that where you have maybe competing planning groups going on?

Isabel Evans: This is Isabel. Here in Arizona, we were concerned that this would be a thing if we had EHE and integrated planning it could get really complicated, which is one of the reasons that we decided to adapt our EHE plan into our integrated plan and basically explain to folks, we did amazing work on the EHE plan. So many ideas came out of it, but we're not going to ask people to do both. We're not going to have people split into two factions. We're going to bring this into our integrated plan. All the amazing work is brought into the integrated planning process, and that way we resolved that issue before it could crop up.

I think one of the reasons that worked well here is that our EHE jurisdiction does cover almost two thirds of our state, so it's a little bit of a different situation from other places, but that was why we aggressively, first of all said, "No, no, no, we're not going to have two plans and two groups." We didn't have to create an EHE committee from the start. It happened with our existing planning body, really, to tackle this first because we just didn't want to have this happen. I think being transparent with our community partners has really helped to say we're all interested in different things, but we all know at the end of the day, two groups, two plans or even three groups, three plans, four plans, it's never going to benefit us all. [inaudible 01:15:46] receptive to it in general.

Travis: Great, thank you.

Carmi Washingto...: Isabel, I am so glad you brought that up because our plan, actually, was built and we started saying that it's built on the foundation of the EHE plans that were developed, and they became the major portions of the appendices to our plan as we began the deliberate development of the IP in Maryland. Our EDE director not only was in every meeting, but has space within every meeting. And

now as we are in the core sessions where we are operationalizing these plans, it's very much a lead and a focus within our meetings.

Travis: Right. Thank you. And I know that's not the only... There was a mention too of having part B groups and part A groups. I came from the state of Missouri where we had part B Missouri, but then you had Kansas City and St. Louis on very opposite sides of the state, and sometimes it was hard to get everyone to come together and play together in the sandbox in a way that was productive. Every jurisdiction has its own special dynamics of course, but that's a good question.

Let's see. Let's move on to the next question. It said, "Would you all be willing to share the tools you are using to implement, monitor and evaluate the plan?" I think actually, what might be helpful, Julie, I'm going to put you on the spot, if you can talk a little bit about what we do with IHAP TAC in terms of making the plans available as well as potentially other tools that site jurisdictions might have.

Speaker 2: Yeah, we can certainly, if folks have any tools or resources they want to share and if they don't want stuff posted. We can always pull together best practices or things you should do in terms of pulling together some type of processes for documenting and monitoring your folks' plans. But I guess in general, to kick it back to the panelists, are there specific tools or resources you're willing to share or thinking about what you've put into place to be able to monitor your plan activities?

Holly: I think one of the things that I forgot to bring up, I think we're going to also develop a dashboard of sorts that would be on the website. That's somewhat simplistic, but it will be something that folks can go to. So I would encourage anybody who's listening to take a peek at that Stop HIV Iowa website. See if what you're looking for is on there. Monitoring, you're probably not going to find that, we're still in development with that. Once it's done, we'd be happy to share. It's going to be really tailored to the way that we did it, even though we modeled it after in-house, it's pretty unique in our focus areas, so I'd be happy to share it. I just don't know how useful it would be for folks who didn't approach it that way. If that makes sense?

Travis: Yeah. One thing I'd like to mention is if you're familiar with the Targethiv.org website, I have HIV share there. First of all, we have the IHAP TAC website, where if you look at that right now we have the previous link to all the previous integrated plans. We will do something similar after we get the links to all the plans from CDC and HRSA for this most recent integrated plan.

Also, if you're not aware, there is a Ryan White HIV program locator on the targethiv.org website where you can go in and look up who's the part B, do they have a website? You'll see the little globe if there's a website for the Part B or part A also. They may not always have all those tools and plans on their website,

but that is also a good place to go for some resources as well. I know we use it quite a bit in our work.

But we appreciate you all being willing to share what you have used. Let's see, let me look here. So this is mostly a question for Carmi. Do you find it difficult for biweekly meetings to happen in person? It says, "For Florida, our planning councils require quorum, and all of our planning councils and advisory committees pull together are volunteers. Do you see that as being a challenge?"

Carmi Washingto...: Well, if the meetings did happen in person, yes, it would be a major challenge. All of our meetings are actually virtual, and not only are they virtual, but we have been using the same meeting link since 2021. So if somebody says, "Oh, I can't find the link." It's like go back to an email from whenever and the link is there. We send out reminders an hour before a meeting, to say the meeting's going to begin in an hour. And to talk about partnerships, our Ryan White Planning Group, their lead sends out another reminder about our meeting a half an hour before our meeting begins so that there are these reminders going out for people to get engaged.

But all of the meetings are virtual. To have it happen biweekly in-person would be a major, major stretch. We know that the turnout is like it is because of the ease of access. Now, we have to work on those people that can't make it on those Tuesdays and Thursdays, and what we can do to help facilitate their involvement. That's one of the reasons for the recordings and the meeting information going out right after that, as well as we coordinate calendars. I coordinate calendars with other centers and other community meetings that are going on around so that we don't overlap or bump heads in the scheduling.

Travis: Thank you. I know different jurisdictions, some are able to do the virtual meetings, some because of different reasons, are not able to. I think the important point is to try to find something that works for your jurisdiction that gets all the people to the table who need to be at the table, whatever that may look like. Whether that's a virtual table or an actual real table.

Carmi Washingto...: That's why we always plan for what we call ACLIPS, a community leaders in-person session. I told you we love acronyms.

Travis: You love your acronyms.

Carmi Washingto...: So we will have ACLIPS in the spring. We are planning for another one now where again, we will gather faith leaders from around the state to come to an in-person session where they can have what is identified as a safe space for them to come and discuss the things that are critical for them and their congregations as we move forward in the planning process. And so that they can see where the priorities that they identified last year, how they've landed in the plan and how those deliverables are moving forward.

Travis: Great. So we also learned today, if you need an acronym, a catchy acronym for something, we'll call Carmi and the folks in Baltimore for help with that. Okay, I realize I skipped over a question, but I think actually, this was answered. Deborah, when you were talking about the website, they did ask what does the website contain? Is it just the goals and objectives? I think you did come back and answer already that right now it's not where it's going to be yet, but it will eventually have the plan, the different documents that pull out the goals and objectives, and more information on there. So keep an eye out for that.

And then also related to the website, the next question says, "I'm interested in websites for outward facing materials, so I can pull some best practices." I guess, I did talk about that earlier. "Are there any available the presenters could share?" Again, we will share what you do have. We try to share anything that we find through IHAP TAC, but also if you use that program locator on targethiv.org. That can be helpful as well. We will make sure to share the websites that Iowa and Arizona have mentioned. Can you just, Holly, again, can you say the name of that website for Iowa?

Holly: Yep, it's stophiviowa.org.

Travis: Okay, thank you. And then Arizona, I don't know if yours is easy to say or if you'd want to send that to [Inaudible 01:25:33] in the chat.

Isabel Evans: Whoops, I was looking for my mute. I think Joanna is sending over information in the chat, but we have hivaz.org. It's on that page. It's a dropdown. So hivaz.org, and I think Joanna is sending over the actual URL for the integrated planning page.

Travis: Okay, great. And Carmi, I don't know, does Baltimore have the integrated plan on a page yet?

Carmi Washingto...: Right now it is not posted on a definitive page as we are updating our website, but we do have plans for that to happen because it has been approved to be posted.

Travis: Yes. Great. Next one we got, it says, "This is not a question, but a thank you for this information." Coming from David of the Community Planning and Action Group in New Mexico. He says, "I am the community co-chair, so really appreciate all the work." We also very much appreciate our panelists. Thank you so much again for being here and thank you, David, for that comment. Next question, are there any specific systems you are using to track the progress on your goals and objectives of the integrated plan or that you plan to use? Are there any specific systems? Holly, I see you unmuted.

Holly: Not really. No. Probably, like I said, the dashboard would be for the indicators, and then I would imagine we would use Excel in creating a workbook is what I'm

imagining that we'll do. I don't know that we'll get any more sophisticated than that. Plus, Excel is great.

Travis: Okay. All right. So that is all the questions we had. We are actually getting close to the end, so I want to go ahead and move on to the next slide. We want to make you aware of some... Oh actually, I'm sorry, this is Alexander's slide.

Alexandra: I don't mind you sharing our upcoming events, and we will like to invite you all to the IHAP TAC second peer panel. It will be focused on evaluating and updating the integrated plan. This will happen on May 10th at two, Eastern time, so stay tuned for registration details. We also have our monthly office hours that happen the second Thursday of each month from three to four, Eastern time. Very important, and we will like to highlight this or mention this. The next one is tomorrow, so please feel free to drop by. There's no pre-registration needed. These meetings are not recorded and there are no set topics. Just come in with your questions, connect with us, the IHAP TAC team and other folks, and we will answer them.

And again, we understand the integrated planning process might feel daunting, but IHAP TAC is here to help. If you're new to integrated planning or will like to have a refresher, we encourage you to start with our introductory online module, which provides an introduction to HIV prevention and care planning by a way of self-paced, convenient, right? It's an online course. If you aren't sure where to start or what you need, visit our website to subscribe to our mailing list, review the resources and tools we have available for all of you. You could also request tailored technical assistance. We have it also available in a culturally and linguistically manner, so feel free to drop by and request your technical assistance as needed. You can access all information via our website on targethiv.org.

Travis: Thank you so much again for joining us today. We really do appreciate and welcome your feedback. Please remember to complete the evaluation. [Inaudible 01:30:08] has just chatted out that link there in the chat. If you can go ahead and take a moment to click on that. I know how I am, if I don't click on it right away, I forget about it later. It will also pop up after we close out the webinar. But I do encourage you to go and click on that link now. Once you see that, please, please, please take a moment to fill it out. It's important for us to make quality improvements in the work that we do. We really do take your comments very seriously.

Go next slide, please? So as we wrap up today, I just want to say thank you to our panelists again for joining us and always being great, wonderful speakers, providing us with really great ideas, and sharing your perspectives. Also, thank you to everybody who joined us today as a participant. Just one last reminder, please complete that evaluation if you have not yet. And thank you and have a great afternoon everyone. Goodbye.

PART 4 OF 4 ENDS [01:31:20]