DRAFT

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

1:45 p.m., Thursday, February 10, 2022

Join Zoom Meeting by clicking on this link:
https://us02web.zoom.us/j/89330219598?pwd=RW9wKzFCWHl6SzRRNG12VndnR21YUT09
Meeting ID: 893 3021 9598 Passcode: 253271
To join via telephone call: (346) 248-7799

AGENDA

I. Call to Order
- A. Welcome and Introductions — Josh Mica and
- B. Moment of Reflection — Steven Vargas, Co-Chairs
- C. Adoption of the Agenda
- D. Approval of the Minutes

II. Public Comment and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization.

III. Overview for New and Returning Members — Tori Williams, Director, Ryan White Office of Support
- A. Nuts and Bolts
- B. Petty Cash Deadlines
- C. Conflict of Interest
- D. Open Meetings Act Training
- E. Timeline of Critical 2022 Council Activities
- F. Purpose of the Committee
- G. Committee Meeting Schedule
- H. Adoption of 2022 Committee Goals
- I. Elect a Committee Vice Chair

IV. Active Projects
- A. 2022 Houston Area Integrated HIV Prevention and Care Service Plan
  1. Foundation Document – Consultant
  2. Resource Inventory – Consultant
  3. Needs Assessment - Consultant
  4. The 2021 Ending the HIV Epidemic Plan – Houston Health Dept.
  5. A Prevention Needs Assessment – Houston Health Dept.

V. Announcements — Steven Vargas and Josh Mica, Co-Chairs

VI. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee
1:45 p.m., Monday, December 9, 2021
Meeting Location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Daphne L. Jones, Co-Chair	Rodney Mills, excused	Crystal Starr
Dawn Jenkins	Tom Lindstrom, excused	Carin Martin, RWGA
Imran Shaikh	Deondre Moore	Zeldra Vawters, HHD
Robert Sliepka	Shital Patel	Tori Williams, Office of Support
Dominique Brewster	Faye Robinson	Diane Beck, Office of Support
Lisa Felix	Steven Vargas, excused	
	Herman Finley	
	Esther Ogunjimi, excused	
	Debra Reagans	

Call to Order: Daphne L. Jones, Co-Chair, called the meeting to order at 2:18 p.m. and asked for a moment of reflection.

Adoption of Agenda: ***Motion #1:*** *it was moved and seconded (Sliepka, Felix) to adopt the agenda.* **Motion carried.**

Jenkins assumed the role of Chair for this portion of the meeting.

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Sliepka, Shaikh) to approve the July 19, 2021 committee meeting minutes.* **Motion carried.** Abstentions: Brewster, Felix, Shaikh.

Jenkins resumed the role of Chair for the remainder of the meeting.

Public Comment: None.

Out of Care Study: Williams said that students from TSU and the Project LEAP class surveyed 12 individuals and the Office of Support Health Planner position is currently vacant. Hence, the out of care study is being postponed for now and we will be discussed in the future.

2022 Joint Epidemiological Profile Supplement: Williams said that the previous health planner did a wonderful job writing as much of the Epidemiological Profile Supplement as possible, he worked very closely with Shaikh and others in the city health department but then he had to leave to start his new position. There were a few pieces left to complete, most of which were the responsibility of the Office of Support. Williams thanked Judy Hung from the Ryan White Grant

Administration and Dr. Shaikh for completing the report. Shaikh pointed out the slight differences between the report sent in the meeting packet and the one sent via email yesterday. He thanked Williams for her leadership in helping to complete the report. Williams added that if the committee approves the report today, it will go to the Council in February. ***Motion #3:*** *it was moved and seconded (Jenkins, Shaikh) to approve the 2022 Joint Epidemiological Profile Supplement.* **Motion carried.**

2022 Integrated Prevention and Care Services Plan: Williams said that the plan is due exactly one year from today. The guidance encourages us to use work done in the past and integrate new ideas. Therefore, we can combine information from the 2016 Roadmap, the 2017 Comprehensive Plan, the 2021 Ending the HIV Epidemic plans and other local, state and national plans to create a new plan. The new plan is also supposed to integrate information from non-HIV documents, such as Healthy People, Sexually Transmitted Infections National Strategic Plan for the U.S. 2021-2025, SAMHSA's Prevention & Treatment of HIV Among People Living with Substance Use and/or Mental Health Disorders, etc.

The Office of Support will hire a consultant to create a foundational document like a crosswalk of local and national plans. We can use the foundational document in the same committee structure used previously for community engagement to set goals, strategies and activities based on the four EHE pillars plus possibly a Quality of Life pillar and maybe one for Retention. The committee can look at this again and make a decision next year.

We also need to report on all of the needs assessments in the area. We have our 2020 Care Needs Assessment but the Houston Health Department hasn't completed a prevention needs assessment in several years. The new Integrated Plan also requires a local resource inventory. A consultant can work on that now. Our new health planner will work with staff at the Houston Health Department, Ryan White Grant Administration and The Resource Group to write some of the components of the plan and will then weave all the parts together for presentation to HRSA and CDC.

Appreciations and Announcements: Jones thanked the committee for their hard work this year.

Adjournment: ***Motion:*** *it was moved and seconded (Vargas, Sliepka) to adjourn the meeting at 2:48 p.m.* **Motion carried.**

Submitted by: Approved by:

Tori Williams, Office of Support Date

Chair of Committee Date

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

2021 Voting Record for Meeting Date December 9, 2021

MEMBERS	Motion #1: Agenda				Motion #2: July 19, 2021 minutes				Motion #3: FY22 Epi profile supplement			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Daphne L. Jones, Co-Chair				C		X						C
Rodney Mills, Co-Chair	X				X				X			
Dawn Jenkins		X						C		X		
Tom Lindstrom	X				X				X			
Deondre Moore	X				X				X			
Shital Patel	X				X				X			
Faye Robinson	X				X				X			
Imran Shaikh	X							X		X		
Robert Sliepka		X				X				X		
Steven Vargas	X				X				X			
Dominique Brewster		X						X		X		
Lisa Felix		X						X		X		
Herman Finley	X				X				X			
Esther Ogunjimi	X				X				X			
Debra Reagans	X				X				X			

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 01-14-20)

1. Affected Community Committee

This committee is designed to acknowledge the collective importance of consumer participation in Planning Council (PC) strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee).

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a presentation where all HIV/AIDS-related drug representatives are invited.

The committee will consist of HIV+ individuals, their caregivers (friends or family members) and others. All members of the PC who self-disclose as HIV+ are requested to be a member of the Affected Community Committee; however membership on a committee for HIV+ individuals will not be restricted to the Affected Community Committee.

2. Comprehensive HIV Planning Committee

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from affiliate membership and expertise.

3. Operations Committee

This committee combines four areas where compliance with Planning Council operations is the focus. The committee develops and facilitates the management of Planning Council operating procedures, guidelines, and inquiries into members' compliance with these procedures and guidelines. It also implements the Open Nominations Process, which requires a continuous focus on recruitment and orientation. This committee is also the place where the Planning Council self-evaluations are initiated and conducted.

This committee will not benefit from affiliate member participation except where resolve of grievances are concerned.

4. Priority and Allocations Committee

This committee gives attention to the comprehensive process of establishing priorities and allocations for each Planning Council year. Membership on this committee does include affiliate members and must be guided by skills appropriate to priority setting and allocations, not by interests in priority setting and allocations. All Ryan White Planning Council committees, but especially this committee, regularly review and monitor member participation in upholding the Conflict of Interest standards.

5. Quality Improvement Committee

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Performance Measures/Outcome Evaluation, which must be looked at within each year and monitored from this committee. Whenever possible, this committee should collaborate with the other Ryan White planning groups, especially within the service categories that are also funded by the other Ryan White Parts, to create shared Standards of Care.

In addition to these responsibilities, this committee is also designed to implement the Planning Council's third legislative requirement, assessing the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, or assessing how well the grantee manages to get funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the Planning Council and whether all the funds are spent. This Committee may benefit from the utilization of affiliate members.

Nuts and Bolts for New Members

Staff will mail meeting packets a week in advance; if they do not arrive in a timely manner, please contact the Office of Support.

The meeting packet will have the date, time and room number of the meeting; this information is also posted on signs on the first and second floor the day of the meeting.

Sign in upon arrival and use the extra agendas on the sign in table if you didn't bring your packet.

Only committee members sit at the table and can vote at the meeting; staff and others sit in the audience.

Members may only vote on the minutes if they were present at the meeting.

Due to County budgeting policy, there will be no petty cash reimbursements in March and possibly April so save receipts and turn them into Georgette for payment in April.

Be careful about stating personal health information in meetings as they are tape recorded and, due to the Open Meetings Act, are considered public record. The tapes must be available for anyone to listen to, including members of the media.

March 1	Feb 11	Feb 28	March 31
2021	**2022**	**2022**	**2022**
Beginning of fiscal year 2021	Turn in all receipts	End of fiscal year 2021. No money available to write checks until possibly early April	Turn in all remaining receipts for fiscal year 2021 or you will not be reimbursed for those expenses incurred between March 1, 2021 and Feb. 28, 2022

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax

MEMORANDUM

To: Members, Ryan White Planning Council
Affiliate Members, Ryan White Committees

Copy: Carin Martin

From: Tori Williams, Director, Office of Support

Date: January 27, 2022

Re: End of Year Petty Cash Procedures

The fiscal year for Ryan White Part A funding ends on February 28, 2022. Due to procedures in the Harris County Auditor's Office, it is important that all volunteers are aware of the following end-of-year procedures:

1.) Council and Affiliate Committee members must turn in all requests for petty cash reimbursements **at or before 2 p.m. on Friday, February 11, 2022.**

2.) Requests for petty cash reimbursements for childcare, food and/or transportation to meetings before March 1, 2022 **will not be reimbursed at all if they are turned in after March 31, 2022.**

3.) The Office of Support may not have access to petty cash funds between March 1 and March 31, 2022. If meetings are held in person during this time, then volunteers should give Rod the usual reimbursement request forms for transportation, food and childcare expenses incurred after March 1, 2022 but the Office may not be able to reimburse volunteers for these expenses until early April 2022.

We apologize for what could be an inconvenience. Please call Tori Williams at the number listed above if you have questions or concerns about how these procedures will affect you personally.

(OVER FOR TIMELINE)

Ryan White Definition of Conflict of Interest

"Conflict of Interest" (COI) is defined as an actual or perceived interest by a Ryan White Planning Council member in an action which results or has the appearance of resulting in personal, organizational, or professional gain. COI does not refer to persons living with HIV disease (PLWH) whose sole relationship to a Ryan White Part A or B or State Services funded provider is as a client receiving services. The potential for conflict of interest is present in all Ryan White processes: needs assessment, priority setting, comprehensive planning, allocation of funds and evaluation.

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

Memorandum

To: Members, Houston Ryan White Planning Council
Affiliate Members, Ryan White Committees

From: Tori Williams, Director, Ryan White Office of Support

Date: January 27, 2022

Re: Open Meetings Act Training

Please note that all Council members, and Affiliate Committee members, are required to take the Open Meetings Act training at least once in their lifetime. If you have never taken the training, or if you do not have a certificate of completion on file in our office, you must take the training and submit the certificate to the Office of Support before March 31, 2022. The training takes 60 minutes and can be accessed through the following link (if you have difficulty with the link, copy and paste it into Google and it should lead you to the correct area of the Attorney General's website):

https://www.texasattorneygeneral.gov/og/oma-training

If you do not have high-speed internet access, you are welcome to contact Rod in the Office of Support and we will see if we can help you access the information.

Upon completion of training, you will be provided with a code that is used to print a certificate of completion. Using the code, you may obtain the certificate from the Attorney General's Office in the following ways:

Print it from the Attorney General web link at:
https://www.texasattorneygeneral.gov/forms/openrec/og_certificates.php

Or, call the Office of Support with the validation code and the staff will print it for you.

We appreciate your attention to this important requirement. Do not hesitate to call our office if you have questions.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2022 Council Activities

(Revised 01-28-22)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location. **The following meetings are subject to change. Please check our website at www.rwpchouston.org or call the Office of Support at: 832 927-7926 to confirm details regarding a particular meeting.**

General Information: The following is a list of significant activities regarding the 2022 Houston Ryan White Planning Council. Consumers, providers and members of the public are encouraged to attend and provide public comment at any of the meetings described below. For more information on Planning Council processes or to receive monthly calendars and/or meeting packets, please contact the Office of Support at 832 927-7926 or visit our website at: http://rwpchouston.org.

All Ryan White Council and Committee meetings will be held virtually January through March 2022, possibly in the Spring as well. Routinely, the Ryan White Steering Committee meets monthly at 12 noon on the first Thursday of the month. The Council meets monthly at 12 noon on the second Thursday of the month.

Thurs. Jan. 27	Council Orientation. 2022 Committee meeting dates will be established at this meeting.
Thurs. Feb. 3	12 noon. First Steering Committee meeting for the 2022 planning year.
Feb. date TBD	10 am, Orientation for new 2022 Affiliate Committee Members.
Thurs. Feb. 10	12 noon. First Council meeting for the 2022 planning year.
Tues. Feb. 15	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. The Council is currently funding, or recommending funding, for 17 of the 28 allowable HRSA service categories. The Idea Form is used to ask the Council to make a change to a funded service or reconsider a service that is not currently being funded in the Greater Houston area with Ryan White Part A, Part B or State Services dollars. The form requires documentation that justifies why a particular service should be funded and why it is not a duplication of a service already being offered through another funding source. Anyone can submit an Idea Form. Contact the Office of Support at 832 927-7926 to request required forms.
Thurs. Feb. 24	12 noon. Priority & Allocations Committee meets to approve the **policy on allocating FY 2022 unspent funds, FY 2023 priority setting process** and more.
March date TBD	EIIHA Workgroup meeting.
Tues. March 15	2:00 pm. Joint meeting of the Quality Improvement, Priority & Allocations and Affected Community Committees to determine the criteria to be used to select the **FY 2023 service categories** for Part A, Part B and *State Services* funding.
Mon. March 21	1:30 pm. **Consumer Training** on the How to Best Meet the Need process.
Thurs. April 7	12 noon. Steering Committee meets.
Thurs. April 14	12 noon. Planning Council meets.
	1:30 – 4:30 pm. **Council and Community Training for the How to Best Meet the Need process**. Those encouraged to attend are community members as well as individuals from the Quality Improvement, Priority & Allocations and Affected Community Committees. Call 832 927-7926 for confirmation and additional information.

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Mon. April 18	10 am – 5 pm, Special workgroup meetings. Topics to be announced.
April 19 - 27	**The following workgroups will be scheduled to meet. Call 832 927-7926 for confirmation and to receive meeting packets.** 10:30 am. ***Date to be announced***. **How To Best Meet the Need Workgroup #1** at which the following services for FY 2023 will be reviewed: • Ambulatory/Outpatient Medical Care (including Emergency Financial Assistance – Pharmacy Assistance, Local Pharmacy Assistance, Medical Case Management, Outreach and Service Linkage – Adult and Rural) • Ambulatory/Outpatient Medical Care (including Medical Case Management and Service Linkage – Pediatric) • Referral for Health Care and Support Services • Clinical Case Management • Non-Medical Case Management (Service Linkage at Testing Sites) • Vision Care 1:30 pm. ***Date to be announced.*** **How To Best Meet the Need Workgroup #2** at which the following services for FY 2023 will be reviewed: • Health Insurance Premium & Co-pay Assistance • Medical Nutritional Therapy (including Nutritional Supplements) • Mental Health • Substance Abuse Treatment/Counseling • Non-Medical Case Management (Substance Use) • Oral Health – Untargeted & Rural 3:00 pm – 5:00 pm. ***Date to be announced***. **How To Best Meet the Need Workgroup #3** at which the following services will be reviewed: • Early Intervention Services • Emergency Financial Assistance - Other • Home & Community-based Health Services (Adult Day Treatment) • Hospice • Linguistic Services • Transportation (van-based - Untargeted & Rural)
Thurs. April 28	12 noon. Priority & Allocations Committee meets to allocate **Part A unspent funds.**
Mon. May 2	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 15 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.
Tues. May 17	11:00 am. **How to Best Meet the Need Workgroup** meets for recommendations on the **Blue Book**. The Operations Committee reviews the FY 2023 Council Support Budget.
Tues. May 17	2:00 pm. Quality Improvement Committee meets to approve the **FY 2023 How to Best Meet the Need results** and review **subcategory allocation requests**. Draft copies are forwarded to the Priority & Allocations Committee.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2022 Council Activities

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Tues. May 24	7:00 pm., Public Hearing on the **FY 2023 How To Best Meet the Need results.**
Wed. May 25	Time TBD. Special Quality Improvement Committee meeting to review public comments regarding **FY 2023 How To Best Meet the Need results**.
Thurs. May 26	12 noon. Priority & Allocations Committee meets to recommend the **FY 2023 service priorities** for Ryan White Parts A and B and *State Services* funding.
Thurs. June 2	12 noon. Steering Committee meets to approve the **FY 2023 How to Best Meet the Need results**.
Thurs. June 9	12 noon. Council approves the **FY 2023 How to Best Meet the Need results**.
Week of June 13-16	Dates and times TBD. Special Priority & Allocations Committee meetings to draft the **FY 2023 allocations for RW Part A and B and *State Services* funding**.
June 12 or Aug. 16	2:00 pm. Quality Improvement Committee reviews the results of the Assessment of the Administrative Mechanism and hosts Standards of Care training.
Thurs. June 23	12 noon. Priority & Allocations Committee meets to approve the **FY 2023 allocations for RW Part A and B and *State Services* funding**.
Mon. June 27	7 pm. Public Hearing on the **FY 2023 service priorities and allocations**.
Tues. June 28	Time TBD. Special meeting of the Priority & Allocations Committee to review public comments regarding the **FY 2023 service priorities and allocations**.
July/Aug.	Workgroup meets to complete the proposed **FY 2023 EIIHA Plan**.
Thurs. July 7	12 noon. Steering Committee approves the **FY 2023 service priorities and allocations**.
Thurs. July 14	12 noon. Council approves the **FY 2023 service priorities and allocations**.
Fri. July 15	5 pm. Deadline for submitting a Project LEAP application form. See July 28 for description of Project LEAP. Call 832 927-7926 for an application form.
Thurs. July 28	12 noon. If necessary, the Priority & Allocations Committee meets to address problems Council sends back regarding the **FY 2023 priority & allocations**. They also allocate **FY 2021 carryover funds**. (**Allocate even though dollar amount will not be avail. until Aug.**)
Wed. July 27	**Project LEAP** classes begin. Project LEAP is a free 17-week training course for individuals living with or affected by HIV to gain the knowledge and skills they need to help plan HIV prevention and care services in the Houston Area. To apply, call 832 927-7926.

(continued)

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2022 Council Activities

(Revised 01-28-22)

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Thurs. Aug. 4	12 noon. ALL ITEMS MUST BE REVIEWED BEFORE BEING SENT TO COUNCIL – THIS STEERING COMMITTEE MEETING IS THE **LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY 2023 GRANT**. (Mail out date for the August Steering Committee meeting is July 28, 2022.)
Mon. Aug. 22	1:30 pm. **Consumer Training** on Standards of Care and Performance Measures.
Fri. Sept. 2	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 15 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.
Tues. Sept. 13	2:00 pm. Joint meeting of the Quality Improvement, Priority & Allocations and all Committees to review data reports and make suggested changes.
Mon. Sept. 19	1:30 pm. **Consumer-Only Workgroup** meeting to review FY 2023 Standards of Care and Performance Measures.
Tues. Oct. 18	11:00 am. Operations Committee reviews the Memorandum of Understanding between all Part A stakeholders & Letter of Agreement between Part B stakeholders.
October or November	Date & time TBD. Community Workgroup meeting to review **FY 2023 Standards of Care & Performance Measures** for all service categories.
Thurs. Oct. 27	12 noon. Priority & Allocations Committee meets to allocate FY 2022 unspent funds.
Tues. Nov. 15 or 29	10:00 am. Commissioners Court to receive the World AIDS Day Resolution.
Thurs. Nov. 10	12 noon. Council recognizes all Affiliate Committee Members.
Thurs. Dec. 1	**World AIDS Day**.
Thurs. Dec. 8	12 noon. Election of Officers for the 2023 Ryan White Planning Council.

2022 Ryan White Planning Council Committee Schedule - DRAFT

(as of 01/28/21)

AFFECTED COMMUNITY

Meetings are on the second Monday after Council meets starting at 1:30 pm.

February 21	July 25
March 15*	August 22
March 21	September 19
April - no meeting	October 24
May 23	November 21
June 20	December - no mtg

COMPREHENSIVE HIV PLANNING

Meetings are the second Thursday of the month starting at 1:30 pm:

February 10	August 11
March 10	September 8
April - no meeting	October 13
May 12	Nov 10
June 9	December – no mtg
July 14	

OPERATIONS

Meetings are Tuesdays following the Council meeting starting at 11:00 am:

February 15	August 16
March 15	September 13
April - no meeting	October 18
May 17	November 15
June 14	December 13
July 19	

PLANNING COUNCIL

Meetings are the second Thursday of the month starting at 12 noon:

February 10	August 11
March 10	September 8
April 14	October 13
May 12	Nov 10
June 9	December 8
July 14	

PRIORITY & ALLOCATIONS

Meetings are the fourth Thursday of the month at 12 pm:

February 24	July 28
March 15*	August 25
March 24	September 22
April 28	October 27
May 26	November - no mtg
June 23	December - no mtg

QUALITY IMPROVEMENT

Meetings are on the Tuesdays following Council starting at 2:00 pm:

February 15	August 16
March 15*	September 13
April - no meeting	October 18
May 17	November 15
June 14	December - no mtg
July 19	

STEERING

Meetings are the first Thursday of the month starting at 12 noon:

February 3	August 4
March 3	September 1
April 7	October 6
May 5	November 3
June 2	December 1
July 7	

***Joint meeting of the Affected Community, Priority and Allocations and Quality Improvement Committees.**

BOLD = Special meeting date, time or place

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 01-14-20)

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2. **Comprehensive HIV Planning Committee**

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from affiliate membership and expertise.

3. **Operations Committee**

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2021 QUARTERLY REPORT
COMPREHENSIVE HIV PLANNING COMMITTEE

Status of Committee Goals and Responsibilities (*means mandated by HRSA):

1. Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan and corresponding areas of the End HIV Plan, in collaboration toward the development of an ending the HIV epidemic plan.

2. *Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status.

3. *Work with the community and other committees to develop a strategy for identifying those with HIV who do not know their status, make them aware of their status, and link and refer them into care.

4. *Explore and develop on-going needs assessment and comprehensive planning activities including the identification and prioritization of special studies.

5. *Review and disseminate the most current Joint Epidemiological Profile.

_____ _____

Committee Chairperson **Date**

2022 Ryan White Planning Council

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(Updated 01-11-22)

Green Text = Committee Mentor Blue Text = New Member

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Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026

Division of HIV/AIDS Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

HIV/AIDS Bureau

Health Resources and Services Administration

June 2021

Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of the Integrated HIV Prevention and Care Plan (hereafter referred to as Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 when the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV AIDS Bureau (HAB) published its first Integrated HIV Prevention and Care Guidance, including the SCSN for CY 2017-2021. This guidance allowed funded health departments and planning groups to submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. As in 2015, the Integrated Plan Guidance for CY 2022-2026 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. It reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of stakeholders including people at risk for HIV and people with HIV. The Integrated Plan Guidance intends to accelerate progress towards meeting national goals while allowing each jurisdiction to design a HIV services delivery system that reflect local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2022-2026 from the Integrated Plan Guidance for CY 2017-2021. These changes reflect feedback from recipients and people with HIV as well as priorities detailed in the HIV National Strategic Plan published January 2021 and the implementation strategies outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative. Specifically, recipients who have already conducted extensive planning processes as part of the development of their EHE awards and in conjunction with CDC's *Strategic Partnerships and Planning to Support the Ending the HIV Epidemic in the United States(PS19-1906)* program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, Cluster and Outbreak Detection and Response plans) may submit portions of those plans to satisfy this Integrated Plan Guidance as long as the Integrated Plan submission addresses the broader needs of the geographic jurisdiction and applies to the entire HRSA and CDC HIV funding portfolio. To that end, the Integrated Plan Guidance for CY 2022-2026 includes the *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* (See *Appendix 1*). This checklist details submission requirements and allows each jurisdiction to determine which elements may require new content and which elements were developed as part of another jurisdictional plan.

Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* and in the updated HIV strategy that will be released later this year, and use data to devise strategies that reduce new HIV infections by 90% by 2030. Proposed strategies should include the implementation of activities that will diagnose all people with HIV as early as possible, treat all people with HIV rapidly and effectively to reach sustained viral suppression, prevent new HIV transmissions by using proven

interventions, and respond quickly to potential outbreaks to get needed prevention and treatment services to people who need them.

Section I: Introduction

In the United States, we have the tools to end the HIV epidemic. During 2015–2019, the annual number and rate of diagnoses of HIV infection decreased in both the United States and six dependent areas. Although numbers and rates decreased overall, diagnoses of HIV infection increased in some subgroups and decreased in others. The work of dedicated individuals across HIV prevention and care delivery systems have contributed to the number of HIV diagnoses decreasing nine percent among adults and adolescents between 2015 and 2019[1], and viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) increased from 69.5 percent in 2010 to 88.1 percent in 2019[2]. However, health disparities persist among gay, bisexual and other men who have sex with men, particularly Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13-24 years; and people who inject drugs[3]. To reach the national goals of reducing new HIV infections by 75 percent by 2025 and by 90 percent by 2030, our systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated.

The Integrated Plan Guidance for CY 2022-2026 is the second five-year planning guidance, developed by CDC and HRSA. This Integrated Plan Guidance builds on the first iteration of the Integrated Plan Guidance by allowing each jurisdiction to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. The Integrated Plan Guidance speaks to the need for aggressive actions necessary to achieve the HIV National Strategic Plan 2025 goals and targeted efforts to end the HIV epidemic by the year 2030.

Specifically, the Integrated Plan Guidance was designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data;

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[1] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2019*; vol.32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021.

[2] Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019*. https://hab.hrsa.gov/data/data-reports. Published December 2020.

[3] Black is defined as African American or Black and Latino is defined as Latino or Hispanic (U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025. (Pp 9) Washington, DC
, https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

2. Address requirements for planning, community engagement and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;

3. Improve health outcomes along the HIV care continuum by using data to prioritize those populations where systems of care are not adequately addressing high HIV morbidity and/or lower than average viral suppression rates;

4. Promote a status neutral approach[4], where testing serves as an entry point to services regardless of a positive or negative result, to improve HIV prevention and care outcomes;

5. Reduce recipient burden by allowing recipients to submit portions of other significant planning documents (e.g., EHE Plans, Fast Track Cities, Getting to Zero, or Cluster and Outbreak Detection and Response plans) to meet Integrated Plan requirements and by aligning submission requirements and dates across HIV prevention and care funding; and,

6. Advance health equity and racial justice by ensuring that government programs promote equitable delivery of services and engage people with lived experience in service delivery system design and implementation.

Relationship to other National Plans and Initiatives

HRSA and CDC recognize that many jurisdictions have established and implemented extended planning processes as part of other local initiatives including but not limited to EHE funding, Fast Track Cities, locally funded Getting to Zero initiatives, or Cluster and Outbreak Detection and Response Plans. To minimize burden and align planning processes, the jurisdiction may submit portions of these plans to satisfy the Integrated Plan Guidance requirements. It is important to note that all submitted plans must address the national HIV goal of reducing the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030. Jurisdictions should review the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025* or subsequent updates to the current national plan by visiting www.hiv.gov and subscribing to receive updates.

National Framework for Ending the HIV Epidemic

It is important to think about this Integrated Plan Guidance within the framework of national objectives and strategic plans that detail the principles, priorities, and actions that direct the national public health response and provide a blueprint for collective action across the federal government and other sectors (see *Appendix 5*). HRSA and CDC

[4] A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated in the same way. Source: Julie E Myers, Sarah L Braunstein, Qiang Xia, Kathleen Scanlin, Zoe Edelstein, Graham Harriman, Benjamin Tsoi, Adriana Andaluz, Estella Yu, Demetre Daskalakis, Redefining Prevention and Care: A Status-Neutral Approach to HIV, Open Forum Infectious Diseases, Volume 5, Issue 6, June 2018, ofy097, https://doi.org/10.1093/ofid/ofy097

support the implementation of these strategies.

In January 2021, the U.S. Department of Health and Human Services (HHS) released the *HIV National Strategic Plan: A Roadmap to End the Epidemic 2021- 2025* which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals[5]:

- Prevent new HIV infections
- Improve HIV-related health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

To achieve these goals, the HIV National Strategic Plan identifies key priority populations, focus areas, and strategies. All plans submitted in response to the Integrated Plan Guidance should incorporate the national goals and strategies detailed in the HIV National Strategic Plan. This should include activities that:

- Leverage public and private community resources toward meeting the goals;
- Address health inequities for priority populations including inequities related to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health issues including but not limited to substance use disorders;
- Create strategic partnerships across a broad spectrum of service systems as a means to lessen the impact of social and structural determinants of health such as systemic racism, poverty, unstable housing and homelessness, stigma, and/or under- or un-employment;
- Implement innovative program models that integrate HIV prevention and care with other services and other service organizations as a means to address comorbid conditions and to promote a status neutral approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the HIV National Strategic Plan, visit: https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf.

In 2019, HHS announced the EHE initiative in the United States coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the HIV National Strategic plan goal of 90 percent reduction in new HIV diagnoses in the United States by 2030, decreasing the number of new HIV infections to fewer than 3,000 per year. The EHE initiative focuses resources, expertise and technology in jurisdictions hardest hit by the HIV epidemic. For more information on the EHE initiative, visit: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview .

[5] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 2-3) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

The Integrated Plan Guidance utilizes the HIV care continuum model and the status neutral approach. The HIV care continuum depicts the stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections. Strategies to address racism and discrimination that threatens HIV public health goals within HIV prevention care, and treatment systems are needed to increase the number of people with HIV that reach and maintain viral suppression.

The adoption of a status neutral approach can improve HIV prevention and care service delivery and outcomes. Persons with positive test results should be linked to HIV care, treatment, and other social support services; and, persons testing negative should be linked, as needed, to biomedical HIV prevention services, such as PrEP, and other social support services.

The HIV care continuum allow recipients and planning groups to measure progress and to direct HIV resources most effectively. HRSA and CDC encourage jurisdictions to use the HIV care continuum to identify populations for whom the service system may not adequately prevent exposure to HIV or may not support improved HIV health outcomes. Additionally, all jurisdictions should include performance measures in their Integrated Plan submission including the core performance measures that measure progress along the HIV care continuum for all priority groups. Please see *Appendix 4* for links to suggested CDC and HRSA data sources, performance measures, and indicators.

Section II: Planning Requirements and Submission Guidelines

HIV Planning Requirements

All CDC DHAP and HRSA HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a system-wide plan for the delivery of HIV prevention and care services and the establishment of an HIV planning group, planning council, or advisory group, also known as a planning body. By design, the HIV planning body must engage people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services.

For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional stakeholders and community members (e.g., AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input. In addition, recipients should broaden their existing group of partners and stakeholders to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for

the purposes of improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories.

When developing the Integrated Plan submission, the planning body should collaborate with the recipient to analyze data for program action and decisions, prioritize resources to those jurisdictions at highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population based HIV health outcomes in those jurisdictions. Through strategic collaborations among stakeholders, HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities. Please refer to CDC's most recent HIV Planning Guidance (HPG) and the RWHAP Part A and Part B Manual for more details about HIV planning processes.

Integrated Plan Development

Integrated planning is a vehicle for jurisdictions to identify HIV prevention and care needs, existing resources, barriers, and gaps and outline local strategies to address them. The Integrated Plan submission should articulate existing and needed collaborations among people with HIV, service providers, funded program implementers, and other stakeholders, including but not limited to other programs funded by the federal government, such as the Housing Opportunity for Persons with AIDS (HOPWA) program and providers from other service systems such as substance use prevention and treatment providers. The Integrated Plan submission should reflect current approaches and use the most recent data available. To ensure coordinated implementation of their Integrated Plan submission, each jurisdiction should include information on the persons or agencies responsible for developing the plan, implementing the plan, coordinating activities and funding streams, and monitoring the plan.

To submit the Integrated Plan, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and stakeholders represented in the planning and concurrence process (e.g., community members, people with HIV, providers, governmental entities). Please see *Appendix 6* for a sample letter of concurrence.

The Integrated Plan submission should include all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Executive Summary
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
    a. Epidemiologic Snapshot
    b. HIV Prevention, Care and Treatment Resource Inventory
    c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2022-2026 Goals and Objectives to be organized by the goals in the HIV National Strategic Plan and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.

In addition to these sections, please use the checklist attached, as *Appendix 1,* to ensure the jurisdiction submits all of the documents needed to meet submission requirements, including existing materials and newly developed materials needed for each required section.

Submission

While there is not a standard template for the Integrated Plan submission, the plan submitted must include all the components outlined in this guidance and include a completed *CY2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist.* Plans must be broad enough to ensure that all HIV prevention and care funding work together to reduce new HIV infections by 90% by 2030. The new written plan should not redevelop existing products such as epidemiologic profiles, if these products are current and up-to-date. Existing versions of these documents may be updated or modified if needed for the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan.

- The Integrated Plan should include information on who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, and CDC HIV planning bodies).

- The Integrated Plan should define and provide the goal(s), which allows the jurisdiction to articulate its approach for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the HIV National Strategic Plan.

All funded jurisdictions (funded by both CDC DHAP and HRSA HAB) must submit an Integrated Plan responsive to this guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

1. Integrated state/city prevention and care plan,
2. Integrated state-only prevention and care plan, and/or
3. Integrated city-only prevention and care plan.

NOTE: All submissions should integrate prevention and care as a mechanism to better coordinate a response to HIV among all partners and stakeholders.[6] Per legislative and programmatic requirements, regardless of the option used, CDC and HRSA expect coordination among funded entities and community stakeholders in the development of Integrated Plan and its submission.

The Integrated Plan submission may include several jurisdictions (e.g., the state, the RWHAP Part A jurisdiction(s) in that state, CDC directly funded cities in that state), but each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of the Integrated

[6] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 45-47) Washington, DC. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

Plan. For jurisdictions submitting city-only or state-only Integrated Plans, the city Integrated Plan should complement the state Integrated Plan, including the SCSN. Additionally, both the city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication and should depict and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHAP and HRSA HAB ***no later than 11:59 PM ET on December 9, 2022***. Submissions should be no longer than 100 pages not including the completed checklist and no smaller than 11pt font. The submission package must contain a completed Integrated Plan that includes the sections detailed above; a *CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* detailing where CDC and HRSA may find each of the required elements; and a signed letter from the HIV planning group/body indicating concurrence, concurrence with reservations, or non-concurrence with the plan. Further details on how to submit your jurisdiction's Integrated Plan are forthcoming.

Monitoring

The Integrated Plan provides an overarching vehicle to coordinate approaches for addressing HIV at the state and local levels. Monitoring the Integrated Plan will assist recipients and planning bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information, and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

Jurisdictions must identify how they will provide regular updates to the planning bodies and stakeholders on the progress of plan implementation, solicit feedback, and use the feedback from stakeholders for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health equity, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan is a "living document" and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process.

To ensure progress on Integrated Plan activities and the Integrated Plan's alignment with funding strategies, CDC and HRSA will engage in monitoring activities both independently and jointly. Recipients will use established reporting requirements (i.e., applications, annual progress reports) to document progress on achieving the objectives presented in the Integrated Plan. These reporting updates should include the jurisdiction's plan to monitor and evaluate implementation of the goals, strategies, and objectives included in the Integrated Plan. Additionally, CDC and HRSA project officers will continue to monitor progress during regularly scheduled calls and will conduct periodic joint monitoring calls with recipients.

CDC DHAP and HRSA HAB remain committed to our ongoing partnership and the provision of technical assistance (TA) services. For TA services around integrated planning, please contact your respective project officers.

Appendix 1

CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section I: Executive Summary of Integrated Plan and SCSN	*Purpose:* To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission Tips for meeting this requirement 1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements. 2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other.		
1. Executive Summary of Integrated Plan and SCSN	Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below.	*New material required*	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Approach	Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.).	*New material required*	
b. Documents submitted to meet requirements	List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.	*New material required*	
Section II: Community Engagement and Planning Process	*Purpose:* To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released. 2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The community engagement process should reflect the local demographics. 5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, especially new stakeholders, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of stakeholders to be included. 6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services). 7. Include community engagement related to "Respond" and support of cluster detection activities.		
1. Jurisdiction Planning Process	Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans such as the EHE plan. Please be sure to address the items below in your description		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Entities involved in process	List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for list of required and suggested stakeholders		
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state-only plans)	Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.		
c. Role of Planning Bodies and Other Entities	Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
d. Collaboration with RWHAP Parts – SCSN requirement	Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.		
e. Engagement of people with HIV – SCSN requirement	Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.		
f. Priorities	List key priorities that arose out of the planning and community engagement process.		
g. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan as a result of updates assessments and community input. 4. Any changes made to the planning process as a result of evaluating the planning process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section III: Contributing Data Sets and Assessments	*Purpose:* To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county.* 2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.		
1. Data Sharing and Use	Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.		
2. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years). The snapshot should highlight key descriptors of people diagnosed with HIV and at-risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the 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. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
3. HIV Prevention, Care and Treatment Resource Inventory	Create an HIV Prevention, Care and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: • Organizations and agencies providing HIV care and prevention services in the jurisdiction. • HRSA (must include all RWHAP parts) and CDC funding sources. • Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. • Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services. • Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves. • Describe how services will maximize the quality of health and support services available to people at-risk for or with HIV.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Strengths and Gaps	Please describe strengths and gaps in the HIV prevention, care and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.		
b. Approaches and partnerships	Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
4. Needs Assessment	Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including: 1. Services people need to access HIV testing, as well as the following status neutral services needed after testing: a. Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression – Needs 3. Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility		
a. Priorities	List the key priorities arising from the needs assessment process.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
b. Actions Taken	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.		
c. Approach	Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3.*		
Section IV: Situational Analysis	Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. Tips 1. New or existing material may be used; however, existing material will need to be updated if used. 2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN. 3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using EHE plans to fulfill this	[redacted]	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	requirement, be sure to include updates as noted below.		
1. Situational Analysis	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	Please note jurisdictions may submit other plans to satisfy this requirement, if applicable to the entire HIV prevention and care service system across the jurisdiction.		
a. Priority Populations	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.		
Section V: **2022-2026 Goals and Objectives**	*Purpose:* To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. Tips for meeting this requirement: 2. *Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area.* 3. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure	[redacted]	[redacted]

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. 4. The plan should include goals that address both HIV prevention and care needs and health equity.		
1. Goals and Objectives Description	List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least 3 goals and objectives for each of these four areas. See *Appendix 2* for suggested format for Goals and Objectives. *Please note jurisdictions may submit other plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.*		
a. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.		

Section VI: **2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up**	*Purpose:* To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: 1. Implementation 2. Monitoring 3. Evaluation 4. Improvement 5. Reporting and Dissemination Tips for meeting this requirement 1. This requirement may require the recipient to create some new material or expand upon existing materials. 2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process. 3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.	[redacted]	
1. 2022-2026 Integrated Planning Implementation Approach	1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met		

a. Implementation	2. Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams including but not limited to HAB and CDC funding.		
b. Monitoring	3. Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*		
c. Evaluation	4. Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.		

d. Improvement	5. Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.		
e. Reporting and Dissemination	6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.		
f. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions made based on work completed.		
Section VII: Letters of Concurrence	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See *Appendix 6* for a sample Letter of Concurrence.		
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)			
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)			

3. RWHAP Part B Planning Body Chair or Representative			
4. Integrated Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		
5. EHE Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.		

Appendix 2

Examples of Goal Structure

Note: There is not a required format for submission of Integrated HIV Prevention and Care goals. This format is provided as an example.

Diagnose (EXAMPLE)

Goal 1: To diagnose XX people with HIV in 5 years.

Key Activities and Strategies:
1) Increase routine testing in XX ERs, acute care settings, etc.
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venue to reach demographic XX

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Medicaid, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of newly identified persons with HIV

Monitoring Data Source: EMR data, surveillance data

Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis by XX% and linked to medical care within 90 days by XX%

Treat (EXAMPLE)

Goal 1: To engage XX people with HIV in ongoing HIV care and treatment in 5 years.

Key Activities and Strategies:
1) Increase linkage to care activities in XX populations
2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venues to reach demographic XX

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, school-based clinics, various professional health care associations, etc.

Potential Funding Resources: RWHAP, State Local Funding, SAMHSA, HOPWA, Medicaid expenditures, Bureau of Primary Health Care (Health Centers), Administration for Children and Families, and other public and private funding sources

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Linkage to HIV care within 30 days of less for # of newly identified persons with HIV; Linkage to HIV care within 30 days or less for # of persons with HIV identified as not in care

Monitoring Data Source: Surveillance, RWHAP, CDC testing linkage data

Expected Impact on the HIV Care Continuum: Increase the number of people receiving ART by XX% and improve viral suppression rates in targeted populations by XX%

Prevent (EXAMPLE)

Goal 1: To increase access to PrEP by X% for priority populations in 5 years.

Key Activities and Strategies:
1) Increase number of providers trained to prescribe PrEP
2) Increase PrEP prescriptions among priority populations

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care (Health Centers), State and/or Local Funding, Minority AIDS Initiative (MAI), SAMHSA, HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): # of providers trained; # of prescriptions for PrEP

Monitoring Data Source: Local databases, medical records data, pharmacy records

Expected Impact on Status Neutral Approach: Increase by XX number the people prescribed PrEP, Increase by XX number the people linked to PrEP services, Increase by XX% in the number of syringe services programs available

Respond (EXAMPLE)

Goal: To increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks in 5 years.

Key Activities and Strategies:
1) Increase involvement of health department staff, community members, and community organizations in response planning, implementation, and evaluation
2) Increase flexible funding mechanisms capable of supporting HIV cluster response efforts

Key Partners: Community members, community-based organizations, HIV care providers, FQHCs, correctional facilities, hospitals, social services providers, people with HIV, health departments, public health professionals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, RWHAP, SAMHSA, HUD/HOPWA, Medicaid, Bureau of Primary Health Care (Health Centers), viral hepatitis funding, opioid/substance use funding, State and/or Local Funding

Estimated Funding Allocation: $X

Outcomes (reported annually, locally monitored more frequently): Establishment of strengthened cluster and outbreak detection and response plans; protocols for flexible funding mechanisms; number of clusters detected; number and description of cluster responses and lessons learned; incorporation of strategies from Diagnose, Treat, and Prevent pillars into responses to clusters.

Monitoring Data Source: Local protocols and reports

Expected Impact on Status Neutral Approach: Increase the number of people in networks affected by rapid transmission who know their HIV diagnosis, are linked to medical care, and are virally suppressed, or who are engaged in appropriate prevention services (e.g., PrEP, syringe services programs)

Appendix 3

Examples of Key Stakeholders and Community Members

Community engagement is a key expectation of the Integrated Planning Guidance. Community engagement involves the collaboration of key stakeholders and broad-based communities who work together to identify strategies to increase coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Each community should select stakeholders including persons with HIV who reflect the local demographics of the epidemic with lived experience and can best help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations. This should include not only traditional stakeholders but engagement with new partners and non-traditional organizations. While the Integrated Plan submission should be done in collaboration with identified Integrated Planning body(s), community engagement may also include assessment processes (e.g., focus groups, population-specific advisory boards) that take place outside of or in conjunction with the Integrated HIV Care and Prevention body(s) and to inform the Integrated Plan submission.

Please Note: Persons or groups with a "*" must be included in the planning process to meet HRSA and/or CDC's legislative or programmatic requirements.

Key Stakeholders to Consider for Planning Group Membership

- Health department staff*
- Community- based organizations serving populations affected by HIV as well as HIV services providers*
- People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*
- Populations at risk or with HIV representing priority populations
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers including (RWHAP Part C and D)*
- STD clinics and programs
- Non-elected community leaders including faith community members and business/labor representatives*
- Community health care center representatives including FQHCs*
- Substance use treatment providers*
- Hospital planning agencies and health care planning agencies*
- Intervention specialists
- Jurisdictions with CDC- funded local education agencies/academic institutions (strongly encouraged to participate).
- Mental health providers*
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*
- Representatives from state or local law enforcement and/or correctional facilities
- Social services providers including housing and homeless services representatives*

- Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners

Examples of Key Stakeholders to Consider for Community Engagement

- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)
- Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC
- STD clinics and programs
- Other key informants
- City, county, tribal, and other state public health department partners
- Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners and private payors
- Correctional facilities, juvenile justice, local law enforcement and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Other key informants

Examples of Community Engagement Activities

- Focus groups or interviews
- Town hall meetings
- Topic-focused community discussions
- Community advisory group or ad hoc committees or panels
- Collaboration building meetings with new partners
- Public planning body(s) meetings or increased membership
- Meetings between state and local health departments
- Social media events

Appendix 4

Suggested Data Sources

Suggested Data Sources:

- Behavioral surveillance data, including databases such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)
- HIV surveillance data, including clinical data (e.g., CD4 and viral load results) and HIV cluster detection and response data. HIV Surveillance Report, Supplemental Reports, and Data Tables: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
- STI surveillance data
- HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data)
- NCHHSTP AtlasPlus (HIV, STD, Hepatitis, TB, and Social Determinants): https://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=ss_AtlasPlusUpdate001
- Medical Monitoring Project: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html
- Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report): https://hab.hrsa.gov/data/data-reports
- AHEAD: America's HIV Epidemic Analysis Dashboard: https://ahead.hiv.gov/
- HOPWA EHE Planning Tool: https://ahead.hiv.gov/resources
- Other relevant demographic data (i.e., Hepatitis B or C surveillance, tuberculosis surveillance, and substance use data)
- Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File)
- Other Federal Data Sources (e.g., Medicaid Data, HOPWA Data, VA Data)
- Local Data Sources (e.g., Department of Corrections, Behavioral Health services data including information on substance use and mental health services)
- Other Relevant Program Data: (e.g. Community Health Center program data).

Note: An update to the Integrated Guidance for Developing Epidemiologic Profiles is forthcoming in late 2021.

References for CDC DHAP and HRSA HAB Performance Measures:

- HRSA HAB Performance Measure Portfolio: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio
- Core Indicators for Monitoring the Ending the HIV Epidemic: https://ahead.hiv.gov/
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Appendix 5

Federal Strategic Plans and Resources

Federal Strategic Planning Documents

- Healthy People 2030: Sets data-driven national objectives to improve health and well-being over the next decade.
- HIV National Strategic Plan: A Roadmap to End the HIV Epidemic (2021– 2025): Roadmap for ending the HIV epidemic in the United States, with a 10-year goal of reducing new HIV infections by 90% by 2030.
- Sexually Transmitted Infections National Strategic Plan for the United States (2021– 2025): Groundbreaking, first ever five-year plan that aims to reverse the recent dramatic rise in STIs in the United States
- Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025: Provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030.
- HHS Ending the HIV Epidemic (EHE): A Plan for America Initiative: EHE aims to reduce the number of new HIV infections in the United States by at least 90% to fewer than 3,000 per year.

Federal HIV Funding Resources

This non-exhaustive list provides web sites to assist with identifying federal HIV funding resources in U.S. jurisdictions.

General

- USA Spending
- Federal HIV Budget

Health Resources and Services Administration (HRSA)

- HRSA HIV/AIDS Programs – Grantee Allocations & Expenditures
- HRSA Bureau of Primary Health Care Health Center Recipients Locator
- HRSA Federal Office of Rural Health Policy, Rural Assistance Center, Rural HIV and AIDS Funding & Opportunities

Centers for Disease Control and Prevention (CDC)

- CDC Division of HIV/AIDS Prevention (DHAP) Funding and Budget
- Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic
- Ending the Epidemic (EHE): Scaling Up HIV Prevention Services in STD Specialty Clinics
- CDC DIS Workforce Development Funding

U.S. Department of Housing and Urban Development (HUD)

- HUD Community Planning and Development Program Listing
- HUD Community Planning and Development – Cross-Program Funding Matrix and Dashboard Reports

Substance Abuse and Mental Health Services Administration (SAMHSA)

- SAMHSA's Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities
- SAMHSA Grant Awards by State
- SAMHSA's Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders

HHS, Office on Minority Health (OMH)

- HHS Office of Minority Health Active Grant Award Locator

National Institutes of Health

- Centers for AIDS Research (CFAR) program

CDC/HRSA Project Officer

Appendix 6

Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert ***concurs or concurs with reservations***] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [insert ***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert ***concurrence or concurrence with reservations***] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date:

Planning Body Chair(s)