



Data to Action:

*Translating Contributing Datasets
into Actionable Integrated Plan
Objectives*

January 27, 2026

3:00-4:00 ET



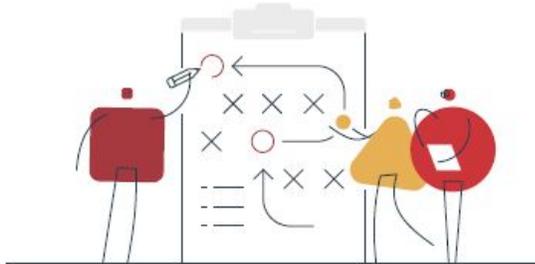
INTEGRATED HIV/AIDS PLANNING
TECHNICAL ASSISTANCE CENTER



About us!



INTEGRATED HIV/AIDS PLANNING TECHNICAL ASSISTANCE CENTER



Conducts national and tailored training and technical assistance



Supports Ryan White HIV/AIDS Program Parts A & B recipients and their planning bodies



Facilitates peer-to-peer sharing and information exchange on integrated planning

ihaptac@jsi.org

Integrated Planning 3.0 learning series!

Integrated planning webinar and peer learning series goals

- Review and discuss the guidance section by section
- Highlight jurisdictional efforts for integrated planning
- Address emerging and ongoing questions
- Facilitate peer engagement and learning

Today's objectives

By the end of the webinar, participants will be able to:

- Identify at least two data inputs for Section III: Contributing Data Sets and Assessments.
- Describe how to synthesize data into Section IV: Situational Analysis to inform goals and objectives (Section V).
- Identify one strategy for presenting data and findings to planning body/council members and a wide range of stakeholders.



Let us know who you are!

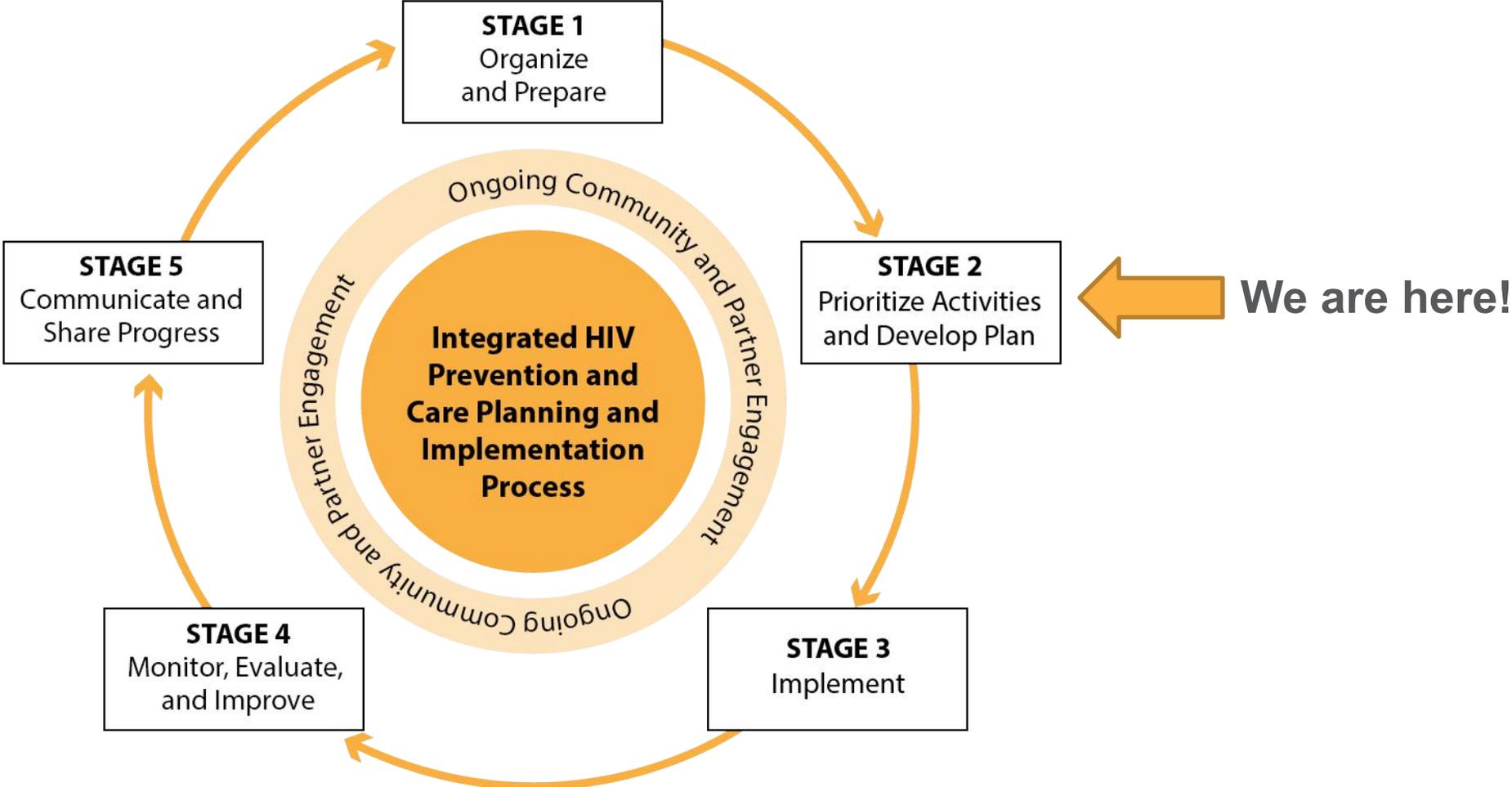
In the chat, please share your:

- Name, jurisdiction/organization, role

Click on “Q&A” located along the bottom of your screen and let us know:

- *What questions do you hope to have answered at the end of this session?*

Stages of integrated planning



How data guides integrated planning

- The Integrated Plan must articulate local, data-based strategies to address **needs, gaps, and barriers**.
- The data highlighted in Contributing Data Sets and Assessments (**Section III**) should inform both the Situational Analysis (**Section IV**) and the subsequent Goals and Objectives (**Section V**).
- Data review and analysis must be performed in collaboration with the planning body and community members to prioritize resources and improve outcomes.



Contributing Data Sets & Assessments (Section III)

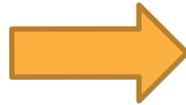
Purpose:

- Analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV affects the jurisdiction.
- Determine the services needed by clients to access and maintain HIV prevention, care and treatment services.
- Identify barriers for clients accessing those services.
- Assess gaps across the HIV Prevention and HIV Care Continuum.

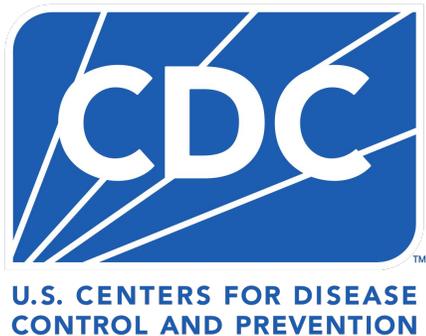
Integrated HIV Prevention
and Care Plan Guidance,
including the Statewide
Coordinated Statement of
Need, CY 2027- 2031

Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

HIV/AIDS Bureau
Health Resources and Services Administration
February 2025



Contributing Data Sets & Assessments (Section III)



Satisfies key legislative requirements:

- Statewide Coordinated Statement of Need (SCSN) (Part B only).
- RWHAP Part A and B planning requirements, including those requiring feedback from key collaborators and people with HIV.
- CDC planning requirements, including those requiring feedback from key collaborators and people and communities disproportionately impacted by HIV.

Suggestions for completing Section III

- ✓ Include submission of portions of other plans*, as relevant:
 - EHE Plan (data must be inclusive of the entire jurisdiction)
 - Getting to Zero Plans
 - Statewide or Regional Needs Assessments
- ✓ Describe how these plans comply with federal requirements, and that data reflect complete jurisdiction (not just EHE priority county).
- ✓ Include quantitative, graphic, and narrative data to describe the needs of people and communities disproportionately impacted by HIV within the jurisdiction.

*applies to other Integrated Plan sections as well

Required components of Section III

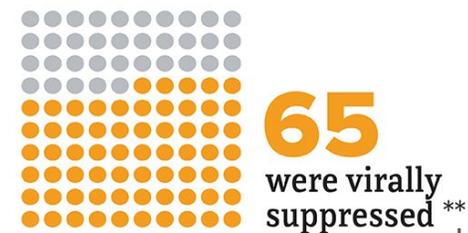
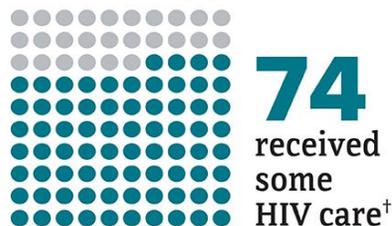
1. **Data Sharing & Use:** Overview of the data used to support integrated planning and relevant data sharing agreements.
1. **Epidemiologic Snapshot:** Current and graphic depictions of trends using the most recent five years of data, highlighting key descriptors for people with HIV and those vulnerable to HIV.
1. **HIV Prevention, Care, and Treatment Resource Inventory:** A detailed assessment of all providers and funding sources, including an Assessment of Strengths and Gaps across the continuum (e.g., geographic gaps, cluster occurrences).
1. **Needs Assessment:** Summary of activities and findings used to inform goals, focusing on barriers to testing, prevention services (e.g., PrEP), rapid linkage to care, and viral suppression.

Epidemiological Snapshot

- Display trends using the most recent five years of available data.
- Include both written summaries and visual representations of the data.
- Key descriptors:
 - People newly diagnosed with HIV
 - People who could most benefit from HIV prevention services
 - People with HIV who do not know their HIV status
- Types of data:
 - Demographic, geographic, and socioeconomic characteristics
 - Behavioral and clinical characteristics
- HIV clusters: Characteristics of identified HIV clusters and linked cases.
- Include a jurisdictional HIV continuum of care visual.

Example:

For every 100 people overall with diagnosed HIV:



HIV Care Continuum, HIV.gov

HIV Prevention & Care Resource Inventory

- **System mapping:** Provides a complete picture of who is currently doing what and where across the entire jurisdiction.
- **Identifying gaps:** Reveals where services are lacking, especially in geographic areas or for populations disproportionately impacted by HIV.
- **Coordination:** Acts as a foundation for demonstrating how the jurisdiction will leverage and coordinate different funding streams to avoid duplication of effort and prevent service gaps.
 - Funding Streams: CDC, HRSA RWHAP, HOPWA, SAMHSA, etc.

Inventory Required Elements



- **Providers:** List agencies providing HIV care and prevention services, including those providing substance use prevention and treatment services.



- **Funding Sources:** Include all RWHAP parts (A-F) and CDC funding, as well as other federal sources (e.g., HUD's HOPWA program, HRSA's Community Health Center Program).
 - **Funding amounts not required**



- **Provided Services:** Detail the services and activities offered by organizations, specifically noting which people and communities disproportionately impacted by HIV are served.

Featured IHAP TAC resource



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HIV Prevention, Care and Treatment Resource Inventory Compiler

Introduction

The [*Integrated HIV Prevention and Care Guidance, including the Statewide Coordinated Statement of Need, CY 2027-2031*](#) (Integrated Plan Guidance) requires an HIV Prevention, Care, and Treatment Resource Inventory. The purpose of this tool is to support the collection and analysis of all HIV resources in the jurisdiction.

The tool was developed for the purpose of responding to the Integrated Plan Guidance. The Resource Inventory Table can be incorporated into the Integrated Plan submission.

It is important to review the Integrated Plan Guidance to confirm compliance with legislative and programmatic planning requirements. The HIV Prevention, Care, and Treatment Resource Inventory is a component of Section III of the Guidance (see excerpt below).

HIV Prevention, Care and Treatment Resource Inventory: Integrated Plan Guidance Requirement Detail

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:

Inventory Analysis: Assessment of Strengths and Gaps

The inventory isn't just a list—it should include an Assessment of Strengths and Gaps across the HIV Prevention and Care Continuum.

This assessment must specifically address:

- Geographic landscape
- Occurrences of HIV clusters/outbreaks
- Underuse of new HIV prevention tools (e.g., injectable antiretrovirals)
- Areas where the jurisdiction may need to build capacity for service delivery
- Areas where there may be duplicative services

Needs Assessment

Mixed-methods approach to identify and analyze barriers across the HIV continuum, addressing the needs of people with and vulnerable to HIV.

Examples:

Testing & Prevention	Linkage & Retention	Health Outcomes	Structural & Supportive Needs
<ul style="list-style-type: none">● Access to testing● Prevention services● PrEP (oral & injectable)● Substance use services	<ul style="list-style-type: none">● Access to HIV treatment● Care maintenance● Case management	<ul style="list-style-type: none">● Maintenance of viral suppression● Management of comorbidities● PrEP retention	<ul style="list-style-type: none">● Access to housing● Health insurance

Presenting data to planning partners

- Translate epidemiological and needs assessment data trends into clear, compelling narratives to guide planning
 - Focus on disparities experienced by people and communities disproportionately impacted by HIV
 - “Map the gaps” – use maps to identify service gaps relative to HIV incidence and need
 - Use findings from the Needs Assessment (e.g., quotes, themes from focus groups) to illustrate client barriers



Call to Action: Use this data-informed community engagement process to establish a shared vision for HIV priority setting.

Jurisdictional spotlight: Oregon

Synthesized 40+ existing data sources (2020-2022) plus new primary data from under-represented voices.

Included surveys, focus groups, and planning body engagement.

- Used Oregon's integrated HIV/STI surveillance database to monitor co-morbidities.

Provided a robust analysis of strengths and gaps across all EHE strategies and state services.



**Oregon's 2022-2026 Integrated Plan and
Statewide Coordinated Statement of Need**



December 2022



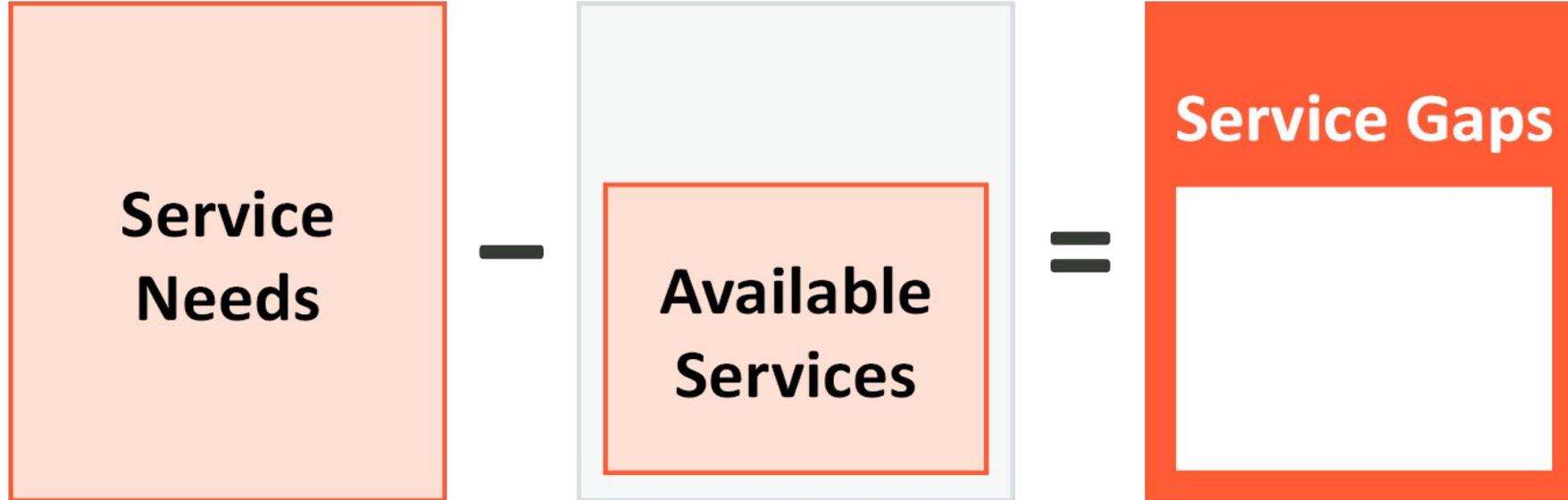
Situational Analysis (Section IV)

Purpose: To provide a detailed summary that synthesizes all information from Community Engagement (Sec. II) and Contributing Data Sets (Sec. III), and inform the goals and objectives of the Integrated Plan.

Required components:

1. Overview of strengths, challenges, and identified needs across the entire HIV prevention and care continuum.
2. Analysis of structural and systemic issues impacting disproportionately affected individuals and communities.

Understanding service gaps



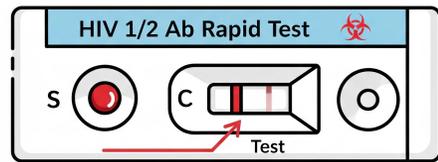
- + Epi Snapshot
- + Unmet Need
- + Data on people with HIV who are unaware of their status
- + Assessment of Service Needs & Barriers

- + Resource Inventory
- + Profile of Provider Capacity & Capability

Gaps determine needed RWHAP services

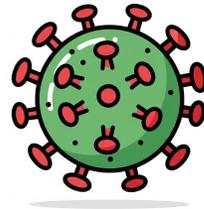
Situational Analysis (Section IV)

The Situational Analysis is organized under the four EHE strategies, ensuring a comprehensive Integrated Plan.



Diagnose

all people with HIV as early as possible.



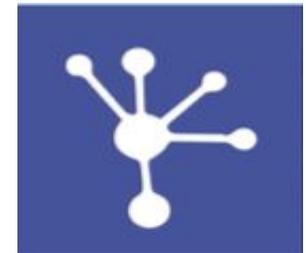
Treat

people with HIV rapidly and effectively to reach sustained viral suppression.



Prevent

new HIV transmissions by using proven interventions (including PrEP).



Respond

quickly to potential HIV outbreaks.

Jurisdictional spotlight: Texas

- **Action:** Texas geocoded residence at time of HIV diagnosis data down to the census tract level to analyze how factors influencing health impact HIV risk.
 - The geocoding allowed a comparison of key indicators across national and state levels to the levels in neighborhoods of people with new HIV diagnoses.
- **Key Finding:** Neighborhoods of newly diagnosed people showed significantly higher adverse factors influencing health compared to state and national levels.



**2022-2026
Texas HIV
Plan**

	Rates for		
	United States	Texas	Neighborhoods of people with new HIV diagnoses
People living in poverty	13.4%	14.7%	15.7%
People who did not complete high school	12.0%	16.3%	19.2%
People who were unemployed	5.3%	5.1%	5.8%
People with no health insurance	8.8%	17.2%	23.7%
People with severe housing cost burdens ⁶	14.4%	13.3%	15.9%

⁶ This is defined by AIDS-VU as the percent of people who spend over 50% of their income on housing.

Jurisdictional spotlight: West Virginia

- Presented their Situational Analysis as a “SWOT” (Strengths, Weaknesses, Opportunities, Threats), organized by EHE strategy.
- Improved accessibility and ease of access for community members.
- Included a strong, highly detailed monitoring and implementation plan.



Pillar 1: Prevent
The mission of the Prevent pillar or subcommittee is to prevent new HIV and HCV transmission by using proven interventions. Over the course of three meetings, 18 stakeholders and partners worked to identify strengths, needs/gaps (weaknesses), opportunities, and barriers/limitations (threats) to prevention and care in West Virginia.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none">Access to Care Mobile services; Quick Response Team (QRT) program; Peer Recovery Support Specialists (PRSS)Education Community levelQuality of Care Dedicated professionals; passion for the workPrograms and Partnerships Ryan White programs; existing collaborations; programs that fit client needsOther Advocacy; innovation and creativity; connection and trust	<ul style="list-style-type: none">Gaps in Access to Care Limited access to PrEP in rural areas; PrEP education and resources; transportation; testing in rural areas; inconvenient locations and times; lack of providers; need for expanded services and mobile blood work; accessibility; lack of communication between service providersEducational Needs Client, community, and provider education needs; need for trauma-informed education; stigma-free care; access to provider mentoring programQuality of Care Needs Stigma free; trauma informed; peer support; specialized care for infectious disease; provider capacity and attitudes; staffing levels; need for confidentialityResource Gaps Housing; naloxone; support services; behavioral and mental health resources; state identification card; outreachGaps in Programs and Partnerships Advocacy; policy; confidentiality among partners; syringe services programs; community service groups; harm reduction program
OPPORTUNITIES	THREATS
<ul style="list-style-type: none">Access to Care Increased testing sites; use of social media; low cost; convenient locations; accessibility; outreach and service promotion; transportationEducation Use of social media and dating apps; messaging; community and provider education; provider mentoringQuality of Care Recovery care; community collaboration; case managementResources Funding; housing; policy; community buy-in; distribute information via pamphletsPrograms and Partnerships Syringe services programs; data sharing; provider mentoring; testing at local pharmacies; expanded pharmacy partnership	<ul style="list-style-type: none">Limitations to Access to Care Lack of services and providers; transportation; inconvenient times; dual diagnoses; lack of mobile care; limited testing; distance to providersEducational Limitations Insufficient education at the client, provider, and community levels; school policy and state lawLimitations to Quality of Care Lack of standardized care; distrust; stigma; need for trauma-informed approach to careResource Limitations Lack of or unstable housing; medication storage; finances; need for harm reduction; other basic needsOther Limitations Politics; fear of police

Goals and Objectives (Section V)



- **Purpose:** Detail jurisdiction's goals for next five years
 - Goals should be broad-reaching and address the priority areas identified in the Situational Analysis.
 - Organized by the four EHE strategies.
- Ensure goals address any barriers or needs identified during the planning process.

Note: Jurisdictions may submit other updated plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and service area

Using data to inform Goals and Objectives

- Objectives must be SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) and trackable via performance measures.

Trend identified in Situational Analysis:

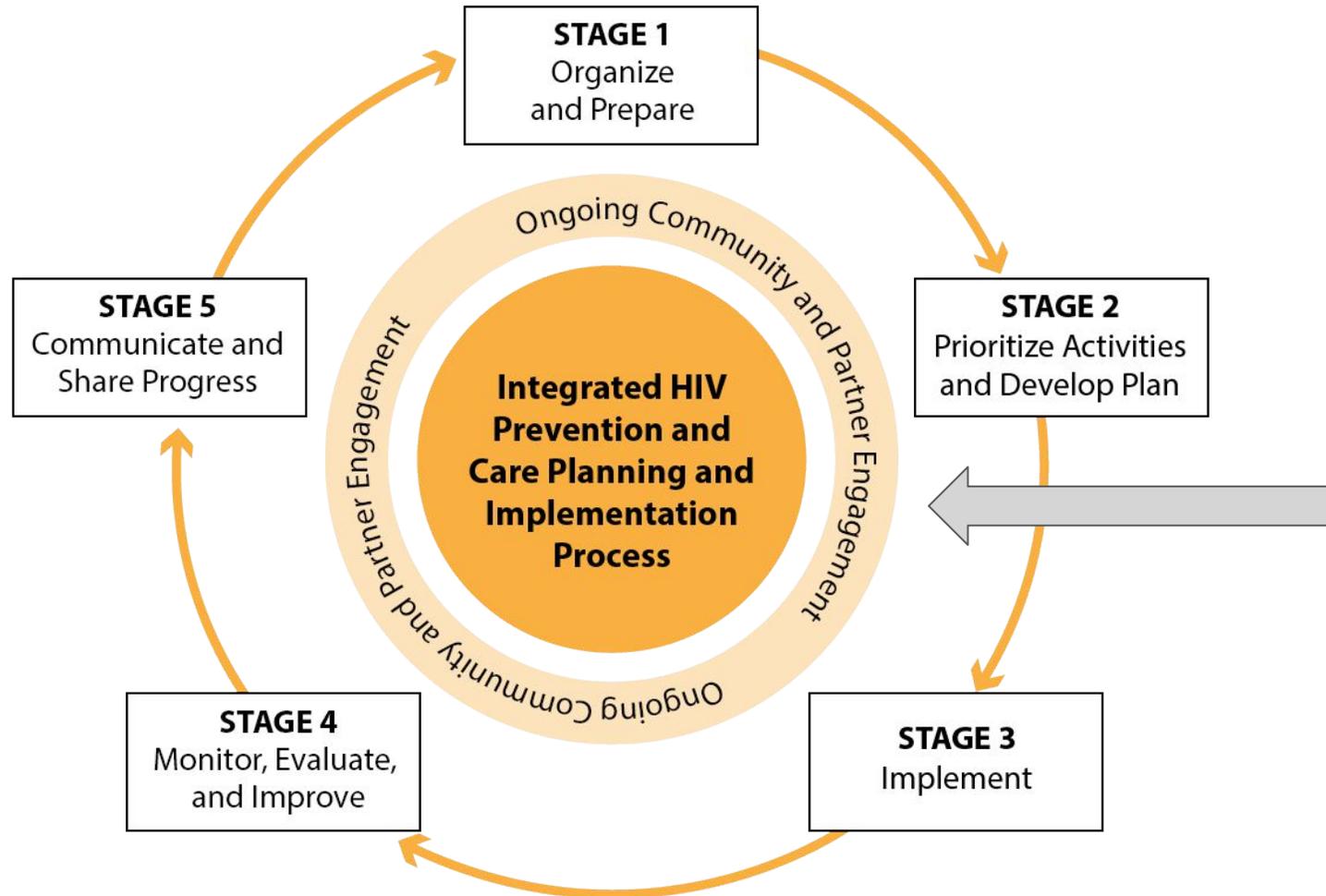
Viral suppression rates are lower among men who have sex with men aged 18-25 relative to other age groups.



SMART Objective:

Improve HIV-related health outcomes among men who have sex with men aged 18-35 by launching Rapid Start ART initiatives at 5 community health centers serving this population by 2029.

The role of community and partner engagement



*Objective development and refinement occurs in concert with **community members, advisors, and implementation partners.***

Next steps: Developing the work plan

- Objectives are integrated into the work plan, which outlines specific activities, responsible parties, and performance measures.
- **Tip:** Use this as an opportunity to ensure you have data sources and assigned procedures for outcome measurements.

Featured resource: Work plan & monitoring table

Integrated HIV and Prevention and Care Plan Work Plan and Monitoring Table, 2027-2031

Goal 1: Example: Diagnose all people with HIV as early as possible.

Objectives	National Goals	EHE Strategy	Activity/Performance Measure	Measure Definition	Baseline	Baseline	Year 5 Targets	Data Source
To increase the number of HIV tests conducted by 20% within the jurisdiction by 2031.		Diagnose	Increase capacity of health care delivery systems to offer routine testing in 20 ERs, acute care settings, etc.	# of HIV tests	2027	15,000	18,000	Epi Databa
				# of newly identified persons with HIV		600	720	
To increase the number of HIV tests conducted by 20% within the jurisdiction by 2031.		Diagnose	Plan and develop a wide dissemination of self-testing kits through system partners across the jurisdiction to improve access for testing	# of HIV self-test kits	2027	15,000	18,000	Epi Databa
				# of newly identified persons with HIV		600	720	

Goal 2: Example: Treat HIV timely and effectively.

Objectives	National Goals	EHE Strategy	Activity/Performance Measure	Measure Definition	Baseline	Baseline	Year 5 Targets	Data Source
To engage and provide access to care for 400 people with HIV by 2028.		Treat	Identify and address mental health barriers for people who have never engaged in care or who have fallen out of care by partnering with mental health providers	# of newly identified persons with HIV linked to care within 30 days	2027	600	720	Epi Databa
				# of persons with HIV identified as not in care linked to care within 30 days		500	780	
To engage and provide access to care for 400 people with HIV by 2028.		Treat	Develop and implement at least one effective, evidence-based, or evidence-informed intervention that improve retention in care	# of newly identified persons with HIV linked to care within 30 days	2027	600	800	Epi Databa
				# of persons with HIV identified as not in care linked to care within 30 days		500	700	

Timeline of activities



Engage Community

Develop needs assessment strategy in partnership with community

Gather Data

Conduct Needs Assessment, gather epidemiological data, identify contributing data sets

Present Findings

Share trends and solicit community feedback

Draft Situational Analysis

Synthesize data, trends, and anecdotal information from Needs Assessment and community engagement activities

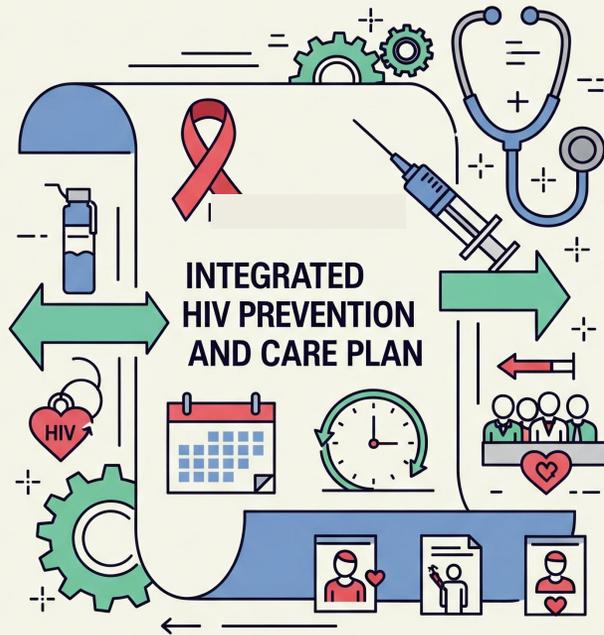
Develop Objectives

In partnership with community, develop SMART objectives and organize within the 4 EHE strategies

Develop Work Plan

Develop implementation and monitoring plan, assigning outcome measures and implementing partners

Implementing the Integrated Plan



- **Keep the plan alive!**
- Adjust to meet the needs as they evolve
 - HIV outbreaks, changes to health insurance, changes to funding amounts, etc.
 - Adjust goals based on new identified needs or programmatic innovations
- Establish a timeframe and process for goal review and progress reporting
- **Sustain community engagement**

Panel Discussion



Jurisdictional Highlights





- 1. What strategies are you focusing on for this planning cycle that is different from last time?**
- 1. How have you or do you plan to involve your planning body in translating needs assessment and epidemiological data into Integrated Plan objectives?**



Questions?

Please take our evaluation!



Upcoming Virtual Event

- **Next Office Hours: Countdown to Integrated HIV Prevention and Care Plan Submission**
 - February 24, 2026, 3:00-4:00 pm ET
- **Purpose: Provide an open space for questions and discussion among peers**
 - Roles and responsibilities:
 - **You!** Ask questions, share your integrated planning experiences, and discuss challenges and successes
 - **Us!** Moderate discussions, answer questions when possible, and document unanswered questions for further follow-up
 - Session will not be recorded

IHAP TAC can help!

- **Contact us at ihaptac@jsi.org to:**
 - Join our mailing list
 - Help you to identify resources
 - Request tailored technical assistance



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Thank you!



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