

**READYTALK**

**Moderator: Gabriela Paz-Bailey**  
**April 27, 2016**  
**2:00 p.m. ET**

Operator: This is Conference # 96536057

Operator: Ladies and gentlemen, thank you for standing by, and welcome to the HHS Implementation Guide to Support Certain Components of Syringe Services Programs 2016 Requesting a Determination of Need Consultation with CDC.

All participants will be in a listen-only mode. Afterwards, we will have – we will conduct a question-and-answer session. At that time, if you have a question, please press star followed by the one on your telephone keypad. If you need to reach an operator at any time, please press star zero.

As a reminder, this conference is being recorded, Wednesday, April 27, 2016.

I would now like to turn the conference over to Ms. Gabriela Paz-Bailey, medical epidemiologist at the Centers for Disease Control and Prevention.

Please go ahead.

Gabriela Paz-Bailey: Thank you, operator.

And good afternoon, everyone. Thank you so much for joining us for this call. As the operator said, we are going to be talking about the HHS Implementation Guidance to support certain components of Syringe Service Programs 2016 and requesting a determination of need in consultation with CDC.

My name is Gabriela Paz-Bailey, and I am a medical epidemiologist at the Centers for Disease Control and Prevention. And I am joined today by Dita Broz, also an epidemiologist at the CDC, and John Brooks, a medical epidemiologist.

I will be presenting all the slides that will be about a 30-minute presentation, and my colleagues will be joining me to answer any questions you may have. So, after the 30-minute presentation, we will open it up for questions and we will be available to answer any questions you guys may have.

So, the HHS Implementation Guidance can be found on the [aids.gov](http://aids.gov) Web Site at the link provided on this slide. And the objective of the talk are to review the HHS Implementation Guidance and the determination of need in consultation with CDC and also to provide practical information and tips for preparing requests for determination of need.

I will start providing you some background. We will talk about the new legal authority for the use of federal funds for Syringe Service Programs. We will go through the process to prepare determination of need in consultation with CDC. That can be either for jurisdictions experiencing increases in viral hepatitis or HIV infections or for jurisdictions at risk of increases. We will also talk about the submission of the request for determination of need. And I will provide some additional resources that may be helpful during this process.

Diagnosis of HIV infection attributed to injection drug use have been declining in the United States after peaking in the late 1980s. And this decline is, in part, due to effective HIV prevention interventions for persons who inject drugs, or PWID, including access to free sterile syringes and risk reduction education.

However, recent trends have suggested increased risk for HIV transmission among PWID that threaten to reverse these earlier successes. The epidemic of prescription opioid use over the past decade and the increases in heroin use have led to increased prevalence of drug injections. And there have been

documented increases in the prevalence of injection drug use among younger people.

Incidence of acute hepatitis C has increased substantially, reflecting high levels of risky injection practices. And, finally, we have experienced a large HIV outbreak among PWID in Southeastern Indiana that highlights the devastating impact of injection drug use in communities that have previously lacked effective evidence-based public health interventions.

We have a very effective tool in our HIV prevention toolbox. Syringe Service Programs, or SSPs, provide access to free sterile syringes and other injection equipment, safe disposal of used syringes and syringe exchange. Most provide other health and supportive services as well, including comprehensive risk reduction counseling, safer injection education, HIV and viral hepatitis screening and also referral to treatment and referral to substance use disorder treatment and medical and mental health care. Over time, these programs have also been called Syringe Exchange Programs or SEPs, Needle Exchange Programs or NEPs and Needle and Syringe Programs or NSPs.

SSPs were first established in the late 1980s in response to the HIV epidemic. Based on the most recent data, there were 2014 SSPs known to be operating in the United States in 2013 with substantially fewer SSPs in rural and suburban areas than in urban areas. Over the past 25-some years, we have collection compelling evidence of SSPs' effectiveness, safety and also cost-effectiveness for HIV prevention among PWID. SSPs have been associated with reductions in injection risk behaviors and in HIV incidence and this so, importantly, in the absence of increases in drug use.

For example, there have been no persuasive evidence that SSPs increase initiation, duration or frequency of drug injection in communities served by SSPs. In fact, many of the recent increases in risk injection practices have been in communities that have not had SSPs. There are also additional documented benefits to SSPs such as enrollment in substance use disorder treatment and higher HIV treatment retention rates. The benefits of SSPs reach beyond enrolled clients through secondary exchange and also through peer outreach.

So, now, federal funds can be used to support certain components of SSPs. The Consolidated Appropriations Act of 2016 modified the restriction on the use of federal funds for HHS programs distributing sterile needles or syringes. The provision still prohibits the use of federal funds to purchase sterile needles or syringes for the purposes of hypodermic injection of any licit drug.

It allows for federal funds to be used for other aspects of SSPs based on evidence of a demonstrated need by the health department and in consultation with CDC. Jurisdictions need to demonstrate that they are experiencing or at risk for increases in hepatitis infections or an HIV outbreak due to injection drug use.

So, what can the federal funds be used for? The federal funds can be used to support staff or personnel – and this would include both program staff but also staff for planning SSP services and for monitoring and evaluation activities – supplies such as alcohol patch, sterile water and cotton; testing kits for viral hepatitis and for HIV; syringe disposal services; navigation services to ensure linkage to HIV and viral hepatitis services, substance use disorder treatment and also medical care and mental health care; provision of naloxone to reserve drug overdoses; educational materials; condoms; communication and outreach activities and also planning and evaluation activities. And, again, federal funds cannot be used for needles and syringes for legal drug injection or for other devices solely used for legal drug injections such as (cookers).

So, how would you apply to redirect federal funds to support SSPs? There are two steps to apply to redirect funds to support SSPs. First, use the determination of need and, second, the process to apply to federal agencies to request approval to redirect fund. But, in today's presentation, we are only going to focus on step one, determination of need in consultation with CDC. And you probably saw the CDC guidance to address step two was released this morning.

So, let us talk about how to demonstrate need. There are, as I mentioned before, two scenarios that may apply to demonstrate need. One is for

jurisdictions experiencing increases and the second is for jurisdictions at risk for but not yet experiencing increases.

If experiencing increases in viral hepatitis or HIV infections, health departments should submit data that shows increases in acute hepatitis C virus or HCV, acute hepatitis B virus or HBV, or HIV infections and also provide evidence that the increases in infections resulted from injection drug use. And this could be simply by presenting data on transmission category if this is available as it is for HIV surveillance data. But, also, epidemiologic surveys of social or ethnographic community data can be used.

So, for jurisdictions experiencing increases, we present an example here with this table on how to present the data to CDC. We will be reviewing the different columns in more detail later in the presentation when I discuss how to prepare and submit a request.

Health departments should describe the outcome being analyzed, the data source, the geographic area that corresponds to the data and the start and ending year of the assessment period, also the measurement of the increases. That could be a number or it could be a percentage or a rate. And you would also need to calculate the relative increase during the assessment period.

This is an example of the narrative that could accompany the data presented. This narrative in this example clarifies, again, the outcome, analyze the percent increases and summarize the evidence to support that the increases were due to injection drug use. And you can find this example in Appendix Two of the HHS guidance so that you can read through the whole thing.

So, some tips on how to present the data. First, the scope of the presented evidence should address the geographic area for which a determination is being requested. This may be a city, county or some other geographic area. In some cases, state-level data could be used if it is well justified. For example, if opioid overdose death data are only available at the state level and the applicant has a reasonable justification that this data likely reflects trends in the smaller geographic area that has a need, such data could be included. Furthermore, if the SSP is expected to cover multiple neighboring

jurisdictions or if multiple jurisdictions within a state are at risk, data from multiple jurisdictions should be presented.

Second, it is important to know that if only one jurisdiction within a state has a need, the CDC determination will apply to that one jurisdiction and any new need in other geographic areas would require a new consultation with CDC. However, if multiple jurisdictions within a state have a need, the CDC determination of need could be requested for the entire state. If CDC's determination applies to the entire state, no new determinations for jurisdictions within the state would be needed. So, keep in mind that you would need to request a determination for the entire state and data from multiple jurisdictions should be presented to support this request.

Data should be interpreted within your local context, which takes into account the local surveillance practices, the disease patterns and also long-term trend. You should provide an explanation for why the current increases are above what is expected given past trend. In the case of HIV surveillance data, you may find that a particular county had zero HIV diagnosis reported for the past 10 years but five new diagnosis of HIV attributed to injection drug use were reported in the past two years.

So, even though the numbers are low, five cases are a substantial increase from the expected zero cases reported in the past. You should clarify that the increased diagnosis of new HIV cases is not likely due to any changes in surveillance recording practices or other factors at the community level such as increased HIV testing that may artificially inflate the numbers.

You will need to provide evidence that the increases in infections resulted from injection drug use. For surveillance data, this is accomplished by examining the transmission category of injection drug use. Such evidence may also be available through other sources such as epidemiological surveys or social or ethnographic community data, as I mentioned.

If transmission category is not available – for example, for hepatitis – there are multiple reports suggesting that a majority of acute hepatitis C is due to injection drug use, and these publications could be referenced. Another

example may be qualitative interviews conducted by local researchers or program staff with newly-diagnosed HCV patients that found that all or most patients reported recent history of injection drug use.

Existing reports and publications of increases in HIV or viral hepatitis may be submitted as supportive evidence too. For example, your jurisdiction – your jurisdiction may have experienced an outbreak of hepatitis C infection and there may be a recent MMWR report document in the outbreak and also documenting recommendations that include establishing a necessity. This would be a very strong supportive evidence to include. But, you must still provide HIV or viral hepatitis surveillance data. This is important if more recent data may be available since the outbreak investigation was conducted.

So, let us talk now about jurisdictions at risk for increases.

For jurisdictions at risk for but not yet experiencing increases, data should come from multiple sources. You should use local data when available because it is likely more up to date than national data. And you should triangulate the data to provide evidence that there is likely an increase in injection drug use. The outcomes proposed in the guidance to be used to demonstrate needs are associated either directly or indirectly with injection drug use. But, applicants are welcome to use other outcomes and data sources that may be different from the ones provided in Appendix One of the guidance if such sources may be helpful in demonstrating need for assistance.

This list of outcomes is part of the HHS guidance. And these are example variables that jurisdictions could analyze to document that they are at risk for increases. They include prevalence of injection drug use that could come from surveys like NSDUH or YRBSS or also from local research, also uptake of SSP services, substance use disorder treatment and admissions related to injection drug, drug-related crime, drug-related overdose mortality and emergency department or other medical care related to substance use.

The guidance also includes example data sources in Table Two and in Appendix One that has a detailed list and links of tools and resources. For example, for the outcome prevalence of drug use and uptake of SSP services,

surveys are listed such as the National Survey on Drug Use and Health and YRBSS. So, again, more detail on how to access the data is provided in Appendix One together with some useful links.

This is an example on how to demonstrate need for jurisdiction at risk that is also part of Appendix Two of the guidance. Health departments could prepare their data the same way as is described in this table. And, again, we will go later in the presentation through each of the columns to provide more detail.

Health departments needs to include a narrative triangulating the different data sources and explaining why all the data together suggest the area is at risk of increases in HIV or viral hepatitis. This example presented here goes through the different outcomes, discusses which outcomes are a direct indication of increases in injection drug use and explains why the increases are considered real and not an artefact or programmatic changes.

So, some tips for presenting strong evidence for jurisdictions at risk for increases. Triangulation of multiple data sources is recommended because, again, a single data source may be insufficient and lead to incorrect conclusions. For example, increases in arrest for syringe and drug possession may be due to increased enforcement by the police force or additional human resources or drug enforcement units. Evidence from multiple data sources that indicate similar trends strengthen the conclusion of increases in injection drug use.

If local data is available, you should use it over national data. Local data may be more timely and relevant. So, for example, rather than relying on federal datasets such as SAMHSA and (TETS) on admissions to substance use disorder treatment programs, request data from the relevant state agency that collects this information or directly from local treatment programs. You can use local SSP (where) program data is available, which may be helpful to show that current services need to be strengthened or expanded.

More direct indicators of transmission risk related to injection drug use are more informative. Some examples of more direct indicators of drug injection are admission to substance use disorder treatment for injection drug use, arrest



records for injection paraphernalia, ER admissions for injection-related injuries such as severe skin and soft tissue abscesses or also overdoses. And some examples of less direct indicators of drug injection are prescription opioid prescribing pattern and drug seizures by law enforcement.

Existing reports and publications that document a risk for a potential increase in HIV or viral hepatitis may be submitted as supportive evidence. For example, CDC recently released a vulnerability assessment report that identifies counties throughout the U.S. that may be at risk for a potential HIV outbreak.

This would be good supporting evidence to include. However, the vulnerability assessment relied on nationally-available data that could have limitations such as timeliness. It also did not include certain data that CDC believes would be very useful for demonstrating need but that at the time that analysis was not available nationally. Therefore, you must still provide data on additional data sources.

So, let us talk about how to prepare and submit a request for a determination of need. State, local, territorial and tribal health departments can request CDC's concurrence for their determination of need. And the determination of need needs to indicate whether their jurisdiction is experiencing or at risk of but not yet experiencing increases in viral hepatitis or HIV infections due to injection drug use.

It should describe the outcomes, analyze the data sources, the geographic area covered, specify the assessment period, the type of measure used, the relative percent increase during the assessment period and, as mentioned previously for jurisdictions at risk for increases, also include a pre-summary of how the data was triangulated or taken together to support this determination.

So, again, the appendix in the guidance can be very helpful since they provide examples on how to prepare and request for determination of need. It could be that, in some situations, you have jurisdiction that are both experiencing increases or at risk for increases. And that would be fine to include both cases into your request.

So, now, we will go through the different elements that are required.

The request should specify the outcomes analyzed. In this example, the outcomes are treatment admissions, heroin-related arrest and overdose deaths. The data sources analyzed for this outcome – in this example, data on treatment admissions that came from the State Division of Alcohol and Drug Abuse. Arrest data came from the county arrest records, and drug overdose deaths were from the state medical examiner.

The request will be reviewed and approved for the specific geographic area. The city or county that the data corresponds on is verified. And, again, if only one jurisdiction within a state has a need, the CDC determination of need will apply to what – to that one jurisdiction and any new need in other geographic areas would require a new request of need to CDC. However, if multiple jurisdictions within a state have a need, the health department could choose to make the request for a determination of need for the whole state. CDC concurrence of need would then apply to the entire state and no new determinations will be needed for additional areas at risk within the state.

So, the beginning and the end of the assessment period need to be specified for each outcome and also the type of measure that is being used. And in terms of (SC made in the) relative percent increase, it would be estimated by the percentage rate or number at the beginning year minus the measure at the end year divided by the beginning year. As discussed, the triangulation of data is very important so that we can rule out changes in programs or additional support to law enforcement that may be artificially creating the increases in trend.

State, local, territorial and tribal health departments should submit the request for need determination to the e-mail address listed in this slide, [sspcoordinator@cdc.gov](mailto:sspcoordinator@cdc.gov). And within days after receipt, CDC will notify the health department whether the evidence is sufficient to demonstrate need.

CDC will provide applicants with documentation that CDC has concurred that they have demonstrated need. With the document provided by CDC, the health department and other federal funds recipient may then apply to

direction upon to their respective federal agency. If the evidence is insufficient, then no programmatic or budget changes will be authorized. Jurisdictions may choose to revise and then resubmit their request with additional evidence based on the feedback that they get from CDC.

So, in terms of additional resources, if you have questions while preparing your determination of need, you should first review the HHS guidance that has detailed examples of outcomes and data sources. Health departments should initially gather the data available and internally assess whether this data indicates possible increases. If additional questions, you can submit request for technical assistance to [sspcoordinator@cdc.gov](mailto:sspcoordinator@cdc.gov). Local health departments should request technical assistance from their state health department and collaborate with them in their submission as state health departments can submit a request for multiple jurisdictions in their state.

These are some helpful Web Sites. The CDC Access to Sterile Syringes Web Site provides useful links, including a link to the CDC Program Guidance for Implementing Certain Components of Syringe Service Programs. And the [aids.gov](http://aids.gov) Web Site hosts the HHS guidelines.

Other resources are listed here. The Community Epidemiology Work Group from NIDA is a network of local drug abuse experts who report semi-annually on drug trends and emerging issues in sentinel sites. Their Web Site – their Web Site also provides great examples on triangulation of multiple data sources on drug use and also provides a contact list for local drug abuse experts. The CEWG stopped in 2014. But, their work is being continued by the NIDA National Drug Early Warning System. And the link for it is provided on this slide.

So, now, we have time for questions. But, before the operator opens the line, I am going to pass it to John Brooks, who would like to make a couple of clarifications.

John Brooks: Thank you very much, Gabriela, for that very comprehensive presentation. I am sure folks wouldn't have a lot of questions. I've just been watching the chat a little bit and wanted to make two quick clarifications.

First of all, these slides and the recording of this webinar will be made available in about one to two weeks. So, keep your eyes open for that.

Secondly, I just wanted to clarify for folks what – how the determination of need fits in with funding requests in general so that everybody understands what we are talking about. In redirecting federal funds for SSPs, the new law that Congress passed first requires the CDC, as Gabriela explained, to be consulting with the jurisdiction that may eventually want to move those funds. But, before the funds can move, they need an umbrella to – the evidence for the determination of need. That is the process we are talking about now.

Once that determination has been made, then HHS funds through any HHS operating unit. So, whether it's HRSA, SAMHSA, Indian Health Service, potentially FCA or CDC could be used for SSPs. So, as an example, if, let's say, a SAMHSA program wants to use some of their funding for an SSP in a certain jurisdiction, then they first need to find out whether that jurisdiction has had a determination of need assessed for it. And we are going to ask after this webinar for point of contacts within every state health department for who will be the person managing this determination of need process for the state health department so that agencies know who to go to ask "Has a determination of need been made for our jurisdiction?" and, if not, how to work together to get one made.

The law is intended to ensure that when the funds are used, they are used appropriately. And our role here is to consult and try and make sure that the letter of the law is met. We don't intend to be a barrier at all. But, we want to make sure that we are doing due diligence.

Gabriela Paz-Bailey: And, again, before I open it up for questions, I also wanted to clarify that the aids.gov Web Site also has links to both the CDC and HRSA agency-specific guidance.

John Brooks: That is right. And SAMHSA will soon be publishing their agency-specific guidance. It's coming up shortly. It takes a little bit of different time within each agency. But, what we are talking about today is this umbrella piece that needs to be in place saying Jurisdiction X – it could be the State of Bliss for

the County of Happiness, whatever it is – you know, they need this – they have a determination that they have need and then agencies can work within that jurisdiction. I'll just mention, as Gabriela had pointed out, the guidance for moving – for getting approval to move CDC funds for specific programs, FOA, grants, whatever was published today.

Gabriela Paz-Bailey: Operator, can we open it up for questions?

John Brooks: It's (inaudible) – I will just mention while you are polling in the first questions that we have 90 minutes to speak. So, we will be here until there are no more questions or we reach 3:30.

Operator: Ladies and gentlemen, if you would like to register for a question, please press star followed by the one on your telephone keypad. If your question has been answered and you would like to withdraw your registration, please press pound. One moment for the first question.

And our first question comes from the line of David Thompson with SAMHSA.

Please proceed with your question.

David Thompson: One clarification. SAMHSA retired. I have one question about the determination of need. Who will be in charge of that? And will there be a committee formed or will there be other agencies involved? Will there be non-federal people involved (inaudible) expertise?

There is a lot of expertise out there already. And, I think, the determination of need can be assisted – there could be assistance from those agencies, whether they would be government (or) SAMHSA's 15 years of experience in outreach to injecting drug users. The (inaudible) (Reduction Coalition) has been doing this even before any federal agency. I think it would be a little more transparent if it was more than one agency that approve the determination of need. Thank you.

John Brooks: David, thank you for that question. That is a great thought. Unfortunately, the law specified CDC as the agency responsible for making the

determination. However, in the process by which that will happen within the CDC, that there is a panel of subject matter experts in epidemiology and surveillance who are able to review these kinds of data, which should be – although it has been a long presentation, I think when you get down to actually pulling the information together, it will be relatively straightforward. It could be as simple for some jurisdictions as simply showing “We have seen an increase in our acute hepatitis C infection rate, and we have evidence that most of those infections are due to injection drug use.”

That being said, this group at CDC is – welcome consultation as we come – as we need it with other (content) matter experts out there. Most of what we are looking is – you know, it is either direct or indirect evidence of the consequences of injection drug use. We are – the place where I think that that kind of consultation and input that show (what we brought up) may be most useful could be for those jurisdiction when they are thinking about “How can I redirect funds? What is the best way for me to use my money now to benefit people who may require syringe service programs and other injection drug-related problems and the complications thereof?”

The other thing I wanted to make a point of is that within each state – and, again, this was specified by the law – within each state, the agency that is responsible for submitting the request for determination of need is the state or local or other tribal or territorial health department. It’s important to note this because in some jurisdictions, the – some of the agencies which are funded by that Department of Health and Human Services may not be part of the public health department.

I am thinking, for instance, in the case of SAMHSA or, potentially, Indian Health Service, that those monies go out to the mental health agency or the substance abuse agency or the tribal and territorial group, which aren’t necessarily part of the health department. So, across jurisdictions, the health department, we hope, will be open to helping facilitate bringing folks together for this problem that really of us are trying to address here today.

Gabriela Paz-Bailey:            Thank you, John.

And before I turn it back to the operator, I just wanted to answer a couple of the questions that were also getting through the chat.

So, one is “Does provision of naloxone include purchase of naloxone?” And the answer is yes. However, it will be dependent on the agency-specific guidance on what can be supported by the cooperative agreement or grant. So, you will have to refer to all the agency-specific guidance and see the list of activities that can be supported by the respective funds.

John Brooks: That is right. And that also applies to questions, for instance, “Can I apply to use existing funds or does this apply to future funds?” What we are talking about today is just the overall areas of need here. The nitty-gritty of “I want to move funds around or apply new funds” will be – that is where the agency-specific guidance will need to be referenced.

Gabriela Paz-Bailey: Thank you, John.

Operator, do we have more questions?

Operator: Yes, ma'am.

And your next question comes from the line of Robert Bellamy with Harm Reduction Action Center.

Robert Bellamy: Hi, guys. Can you hear me?

John Brooks: Yes.

Robert Bellamy: OK. A quick question. Is there anything that SSPs can do besides just putting the data together at this time to sort of spur this process with our county and state health departments? In other words, if we feel like we have a need, who – what course of action, if any, can we take at this point to get the ball rolling moving towards this funding as an - as an SSP, as a – as a non-profit organization?

(Deetap Braz): Hi. This is (Deetap Braz). Thank you so much for that question. I think, we would suggest – since health departments, either local or state, need to be or should be included and involved in submitting the determination of need to

CDC, that you start reaching out to your local – to your health department and see who would be responsible for this submission on behalf of the state and what kind of data can you contribute or expertise can you contribute to help develop that determination of need submission.

And -- go ahead.

John Brooks: I was just going to add that data from SSPs could be remarkably potent here.

Robert Bellamy: Right.

John Brooks: If you can show (that there is risk – it is increasing demand), which I think many SSPs are experiencing, that is strong evidence that there is an increase in problem. It's hard to think of other secondary reasons why there would be a sudden increase in demand for SSPs other than increase in injection drug use behavior.

Robert Bellamy: Right. In our general – sorry.

John Brooks: Go ahead.

Robert Bellamy: OK. Sorry. In our – in our general area – because the trend we are seeing is like somewhat of a decrease in hep C and HIV infections. But, we are seeing a significant increase in injection drug use in general as well as overdose and whatnot. So, we have some pretty significant data, I think, that we would be able to contribute to our state health department. So, I guess, it's just a matter of tracking down who is in charge of this over there and getting the data to that person.

John Brooks: Thank you. And I will just that data from multiple jurisdiction within the state is particularly useful because that fits in with this principle that an entire state could be given this determination if the evidence is such that it's not localized to one part of the state. And the example I like to think of here when talking to people about it is what would you do with a vaccination program? Let's say you are having measles in your state and there is an evidence of measles outbreak in a couple of different towns. You are not going to limit the



administration of the prevention services just to those town because the measles may spread to another place.

We want to states to be able – and/or jurisdictions – to be able to respond quickly to that demand and meet it – so, the – an anticipated demand that may be there. We don't want to be in the way of getting the service there by requiring that county which may not have had the determination originally – that has to go back to (the well) and get that determination made. So, the extent – so, the – in principle, the larger the jurisdiction that can be – for which a justifiable determination of need can be submitted, the better.

Robert Bellamy: Great. Thank you.

Operator: And your next question comes from the line of Emma Roberts with Harm Reduction Consultation.

Emma Roberts: Hi. This is Emma. Can you hear me?

Gabriela Paz-Bailey: Yes, Emma. Go ahead.

Emma Roberts: So, mine is a bit of a piggyback question on the last one. If – so, just to clarify, you are saying that there would be a representative in every state health department who will be given the responsibility to be the contact person for submitting information relating to a determination of need? Correct?

John Brooks: It really will depend on the state health department. We – you know, we can't dictate what they do.

Emma Roberts: Right.

John Brooks: But, we would encourage them to identify point of contact or at least the office the somebody needs to go to. We will be – if that hasn't gone out yet – I'm looking at my colleagues. But, we will be soliciting that information soon. And I am sure many of our state public health colleagues are on this call today and may begin to begin thinking about that as well. And as that comes in, we'd like to be able to make it available so that folks know so either

when they call us or they call the state we can refer folks to the right place to coordinate a – the largest joint request for determination of need possible.

Emma Roberts: OK. That is – I mean, that would be really helpful because the Harm Reduction Coalition – we work nationally to provide capacity building services and have been in relation to this recently with a lot of areas where there is emerging trends and increases in injection drug use and elevated HIV and hep C rate. And, sometimes, the groups that we work with on the ground feel that there is a disconnect from the state or even, sometimes, the local health department or they feel that the local health department might not be taking their concerns (they see originally) as what they are seeing (happen) on the ground.

So, it's great to know that you will be supporting this process of having contact people where possible. I understand that you can't dictate these things to the state health department so that people will then know where to go to – you know, to take their concerns and to take their data and information that they are seeing. So, that is really good to hear. Thank you.

John Brooks: And, Emma, I will just add one thing to that, which I – you sort of – what I heard in what you were saying – you reminded me that there are places in this country where state and local law still prohibits the prohibition of either an entire service – Syringe Service Program or various elements thereof. That doesn't mean that that jurisdiction can't apply (if they want) a determination of need. It only means that despite the evidence of need, right now under state and local law, funds can't be used for that purpose.

Emma Roberts: That is really helpful. Thank you.

Operator: And your next question comes from the line of (Alexandra Rolfe) with California Department of Public Health.

(Alexandra Rolfe): My question is about page 20 of the HHS guidance.

John Brooks: (Alexandra), can you speak up just a bit? I'm sorry ...

(Alexandra Rolfe): Sure. (Let's try that). My question is on page 20 of the HHS guidance. And under the heading "Part B – Data Sources," it says that these multiple sources of data, when triangulated, should provide compelling evidence that there is likely an increase in injection drug use in the jurisdiction.

Now, that is different than what is said elsewhere in the document where it is not specified that you have to prove or indicate some kind of increase in injection drug use. You have to show that you are at risk for increases in – potential increases in hepatitis C or HIV infection. So, can I get some clarification on that?

Gabriela Paz-Bailey: I'm sorry. You will have to repeat where you see (that information).  
Yes?

John Brooks: Yes. I see – I see where – I see where (Alexandra) is referring to. And I will just note thank you for that pick up. First of all – so, I think this may have been a copy editing issue. But, the concept here is that you provide evidence that, as you pointed out, the principal is – this is what the federal law says. It's that you have to demonstrate that, in this case, there is a risk for significant increase in viral hepatitis or HIV infection due to injection drug use.

So, some of these sources need to somehow tell us that the – whatever – if there is not – if there is not presently – if you are not presently showing an increase in hepatitis or HIV, then the only thing you have to demonstrate is that there is indirect evidence of injection drug use that puts that community at risk for those conditions.

(Alexandra Rolfe): OK. That is good. Thank you.

(off-mic)

(Alexandra Rolfe): I hope (that's what it meant).

John Brooks: OK. (So, you thought that's what it meant)?

(off-mic)

Operator: And your next question comes from the line of (Tim Kenley) with Washington State Department of Health.

(Tim Kenley): Hi. Yes. So, I was curious – one is a clarification question. So, it's stated that – for the CDC guidance that any programs that are currently existing and funded through state sources or other non-federal sources cannot utilize the CDC funds. Is that correct?

John Brooks: Is that from the guidance that came out this morning, (Tim)?

(Tim Kenley): Yes, it is.

John Brooks: OK. So, this call is about the HHS guidance on determination of need. There will be a different call for all CDC grantees specifically around the guidance that you are referring to. The people we have at the table today are not those that are able to address that question, unfortunately. We have to wait until we've got that – someone else have got that webinar together.

(Tim Kenley): Wonderful. Thank you.

John Brooks: Sorry about that. Yes.

Operator: And your next question comes from the line of (Holly Bierra) with HRSA.

(Holly Bierra): Hello.

John Brooks: Hi, (Holly). Are you at HRSA?

(Holly Bierra): Yes. Hi. How are you?

John Brooks: (All right) (inaudible) HRSA.

(Holly Bierra): That is HRSA. OK. So, I have a few questions because we have – we fund multiple jurisdictions, state and counties alike, as you know. So, requests could come from multiple sources. And I just want to clarify if it's – if it's a city or a local program that is funded, they just want to go to their local health department. It does not have to be a state request unless there is multiple jurisdictions. Correct?

John Brooks: That is correct. If it is conceivable, let's say, that you have a grantee in a single county and that may be the only place in the state that is interested or has a need, then only – the only (thing that needs to be place so there is a) determination of need that that county has a need. (And that need) ...

(Holly Bierra): OK. So, a city (may, for example), say, for Part A HIV AIDS program, they would still need to go to the county health department, it sounds like.

John Brooks: A city health department could also – it's any health – the way the law is written, it basically says any health department at any level of government.

(Holly Bierra): OK. Great. I have another question, if it's OK if I can throw you a couple.

John Brooks: Sure.

(Holly Bierra): We have – we have programs that are already funded with Ryan White funds. If those programs, by chance, are already supporting SSP services, not needle exchange but services around SSP (California) and so forth, do they need to submit a new request to redirect federal funds?

John Brooks: That would depend on what the HRSA guidance says. The – you know, I can't recall who, I think – who is it within HRSA that is managing their guidance. I think, it might have been – I don't know off hand. But, you may need to ask up. Maybe their (inaudible) office would know who is the point of contact for the federal – redirection of federal funds for HRSA grantees.

(Holly Bierra): OK.

John Brooks: But, they – if they are all – what we are talking about is just the determination that is basically showing the evidence ahead of time that there is a problem so that these programs may be – may be allowed to redirect their funds. That is the way the law is written unfortunately. They first have to show that there is a need.

Gabriela Paz-Bailey: This is if they have to move funds that are supporting certain entities to support others.

John Brooks: Right. That is right.

Gabriela Paz-Bailey: So, you are right that it would depend on the agency guidance.

John Brooks: Right. It would be – it would be – it would be wise to first have in place the – that that health department has submitted to us or – yes, ideally, it would be the largest jurisdiction possible had submitted the request to say that we have a need for SSPs. The fact that there is an SSP in the community speaks in some part the fact that there is a need. So, that kind of makes it a little – it makes a little – that is good, helpful information that would help us feel very confident that the request for determination is one that we would concur with.

I will just mention that if – let us say a determination of need is made for County X and your grantee is City Y within County X. City Y is fine, then. They are covered by that determination. So, they don't have to apply separately. But, you see, understand what I am getting at that the larger the jurisdiction that's covered, the easier it would be to then skip this step next time. You just have to do it once.

(Holly Bierra): OK. Got you. Great. All right. And the report that you mentioned that discusses the locations that are considered vulnerable, at risk or currently experiencing or have experienced an epidemic, is that located on the CDC site? Is there a link to that?

John Brooks: It's not presently on our Web Site. We shared it with state and local health departments a couple of weeks ago.

(Holly Bierra): OK.

John Brooks: I sent – I sent – there are copies that I sent over to (Laura Cheever)'s office, who is (Rivoletto), I think, and (Heather Hawk).

(Holly Bierra): OK. I just figured I would ask.

John Brooks: Yes. (Inaudible). The reason it's not on our Web Site is because of the following. We want to get the information out. We think it is potentially actionable. But, we are waiting peer review to make sure – to really get an

imprimatur from other scientists like ourselves that the way we did – conducted the analysis and our evidence were methodologically sound, which we think they are. But we want to make sure that we get that sort of check made before we share it more widely.

(Holly Bierra): OK. Great. Thank you so much.

Operator: And your next question comes from the line of (Kinsey Cham) with Minnesota Department of Health.

(Kinsey Cham): Hi. Thank you for taking all these questions. My question relates to timeline. Are there any kind of concrete deadlines that these requests need to be made by or will it be kind of a rolling deadline?

John Brooks: All right. So, the determination of need – you can apply for that at any time starting right now. There are deadlines, however, potentially, for different programs. So, for instance, if CDC has – I don't – we – the details are – were they in the guidance today? Yes.

So, the guidance that went out today specifies for existing programs – and, I think, there are a variety of grants that went out that within – (which) programs may be eligible to redirect funds during this fiscal year for SSPs and the timeline by which the determination of need needs to reach us so that we can make that assessment and that, then, the project officer in the second step can work with the state to make sure that funds are redirected within the – by the end of the fiscal year given all of the various processes that we have to go through here with our Program and Grants Office.

(Kinsey Cham): And if that deadline – let's say that deadline for the CDC is not met, it could be possibly processed for the following fiscal year, I assume.

John Brooks: That is right. If you – if you – if you – anything that is processed – once this is processed – once we have – once we have concurred with the state that, “You know what, Minnesota, you've got a – you have a need for SSPs (in a lot of parts) of your state. So, we would concur that the application – yes, Minnesota really have met the criteria for determination of need” – from that

point forward any – there is no longer a need to come back (for that) determination.

You could just work directly with the program officers at CDC or any other HHS-supported program under the guidance from that agency to redirect funds or direct funds if it's a new – a new grant or a new funding mechanism.

(Kinsey Cham): Great. Thank you.

Gabriela Paz-Bailey: And I wanted to clarify also that once CDC concurs with the determination of need, it's effective immediately and it doesn't have an expiration date.

John Brooks: That is right. The only reason it might change is if there were some changes in federal law. But, right now, barring any change in federal law, we want the determination – we intend the determination to be – to stay in place because the problem that we are addressing is not just going to go away. You know, as long – that is the – again, going to the vaccination model. Once you institute a vaccination program and there is no more measles, you don't say that is a reason now to withdraw the program. You have to keep the program in place to keep measles at bay. And the same principle applies here.

Operator: At this time, ladies and gentlemen, if you would like to register for an audio question, please press star, one.

And your next question comes from the line of Ms. Melissa Boyette at the Alaska Department of Health.

Melissa Boyette: Hello.

John Brooks: Hello.

Melissa Boyette: I am from Alaska.

John Brooks: Hello.

Melissa Boyette: I had a question about – so, how likely is it – I am within HIV surveillance. And I know that our hepatitis coordinator is also aware of this process. How



likely is it that like Division of Behavioral Health substance abuse folks, SAMHSA-funded folks, tribal folks are aware of this? How well is it being distributed across programs that receive federal funds? And who do you envision taking the lead on this monster data project?

John Brooks: Well, the – we have been distributing through HSS, who then should be moving it out through the different operating divisions. And we certainly – those are – at least three agencies – SAMHSA, HRSA and CDC – have been sharing amongst ourselves what each one is doing. And IHS has also been involved and I had a long good conversation about how they might manage this. So, to communicate this, particular to tribal areas and – our territorial areas are usually informed through our off-the-state and territorial health services here at CDC.

But, I would also encourage anyone on the phone call to please share this with anybody you know or who may be interested. You know, just because we put it out there, we don't necessarily get confirmation that it has been received or read or understood. And, so, we really will depend on folks that have been part of this call today and that are vested in the process to help us move it forward.

And it does (seem actually) – I appreciate your point. But, it does seem like a data monster. But, just realize it may be simpler in some cases than people think. You know, we have anticipated places where it could be very complicated. But, if you've got good, strong evidence of multiple places in the state where hepatitis C rates are – or acute hep C rates are going up and you can't attribute it to anything else but injection drug use or that is the main contributor, that would be very, very powerful evidence for us to grant a concurrence.

Gabriela Paz-Bailey: Yes. It is very important also to reach to your local partners who ...

John Brooks: Yes.

Gabriela Paz-Bailey: ... may actually have other data right at their fingertips, data that may be – they may be analyzing regularly and they could help you prepare the request.

John Brooks: I will just add – knowing that – of the roughly 600 tribal communities in the United States, 300 of them roughly are in Alaska that, you know – that – it may be that some of the – many of them are just small villages. But, nonetheless, some of those may be interested or that may be wanting to work with the state.

And, right now, my colleague at IHS, who is helping us with this and I – are asking folks to bring those to us through the Web Site that was in the webinar today on a case-by-case because with each tribal community, there are a lot of individual considerations that you have to take into account. It is hard to have a one-fits-all solution in that particular case. But, as we said earlier, we want to help places make that happen. So, if we get a request for determination and we see that it is not quite there yet or it needs something else, we are going to give very concrete and, we hope, helpful advice about how to really firm it up so that it's ironclad.

Melissa Boyette: Yes. I am just trying to figure out which – you know, we are so siloed within the work that we do. Which agency could – frankly, the HIV data is the least compelling data that we have. But, I get the feeling that it is sort of like HIV should do this. And it's so small and so underfunded in all the things we already do that I am just trying to figure out if this isn't, you know – I don't know. I will figure it out, probably. But, I can't tell who is supposed to take the lead.

John Brooks: I hear your concern. I just want to point out (inaudible) – it's our Division of HIV Prevention that has been helping with this now. This is really an issue that touches many, many parts of public health – viral hepatitis, people who have worked – (have worked) other medical complications of injection drug use – so, endocarditis, skin and soft tissue infections substance abuse, mental health, crime pharmaceutical distribution.

And you are right. In some places, the areas that cover these are very siloed. Law enforcement may not be speaking to the pharmacy board and they may not be speaking to the mental health authority. And, so, this is – we would encourage folks to begin to try to reach out to all those places that may have

information that could help inform determination of need. You know, there may be law enforcement data or your viral hepatitis colleagues may be sitting on some hepatitis data that could be very, very useful.

Melissa Boyette: Thank you.

Operator: And your next question comes from the line of (Charles Sinclay) with New York State Department of Health AIDS Institute.

John Brooks: All right.

(Charles Sinclay): Hi. Thank you for this webinar. My question is on application at the state level. If a state entity is to provide data for the determination of need, how fine-grained does that have to be? There are, perhaps, 60 counties in New York state. There is need in, probably, every area. Do you do it by county by county? Or do you – how do you – are we allowed to determine what the jurisdiction is?

John Brooks: Yes. Excellent question. And I know New York has a lot of counties and, I think, Kentucky and Georgia are also right at the top. It's a problem because those states and many others – there's multiple counties within the state that have a need. What I would recommend is if you are able to pull data and show for either – maybe – you know, we have given this example of a sheet to fill out. And that is designed for places that may have limited data where it would be pretty simple. We didn't want to make it burdensome.

But, let's say you have the advantage of being able to show in some kind of mapping that rates of hepatitis in these counties have gone up and they are really clearly in red and is well-defined, these were the time period of interest and this was the change over time that would be – that would be very – that would be very, very useful. You don't have to go – what I am trying to say is tabulated data or other geographically-illustrated data where it's based on very complete information that we could ask for the dataset – for instance, if we wanted to just touch base to make sure we all agree – would be sufficient.

(off-mic)

(Charles Sinclay): OK. So, I think that does help. But, you are saying you are not restricted to the table you provided, that you can provide supplementary kinds of documents such as maps, tables, pie charts, perhaps ...

John Brooks: Yes.

(Charles Sinclay): ... to support that determination.

John Brooks: I guess, if you are – absolutely. And that table was meant to make it – you know, there – we were anticipating there would be places that may have – may not be as well-resourced and have much – unfortunately, have less of a problem, let's say, than New York and have to work hard to pull from the other. But if you have a viral hepatitis report for the state that shows from 2010 to 2013 rates have gone up 200 percent in half your counties, that is pretty strong evidence for us that you've got a need, and we would concur with that request, I think.

(Charles Sinclay): OK. And, then, can I ask a follow-up question? The gentleman from Washington state had asked the question about programs that were already funded through state or local agencies that were – I didn't understand the question. And it was from the guidance that came this morning, which I haven't seen. Can you repeat that, what that was referring to?

John Brooks: Yes, I can – I am not – I have – we may have heard it differently. And, so, I apologize there. But, I thought the question was referring – but, I can answer it two ways. I thought the question was referring to what to do about places that – place – something that may be – where they – a person – they want to use funds right now from any HHS agency like CDC, HRSA, SAMHSA to support an SSP – that is – that is contained in a separate guidance what went out today.

Whatever – if anything that is supported by the state or local health department that is not federally-funded does not – this does not apply. So, they could continue following whatever the rules are for those funds according to the funder. This – what we are talking about today only applies to funds provided by the U.S. government.

(Charles Sinclay): Right. You know, I understood that part. I just – I just heard something that sounded strange. OK. Thank you.

Gabriela Paz-Bailey: And just a question from the chat that may also be related to that says “Please clarify this is only to apply to redirect funds that a jurisdiction currently gets and not to apply for new funds, correct?” So, the law establishes that the determination of need and the concurrence from CDC needs to be in place before SSP programs – before federal funds can be used to support SSP programs. So that actually applies for existing funds as for any new cooperative agreements that is established in the future until the law changes.

However, the specific guidance from the agencies may be specific for funds that are already awarded and the process to redirect funds. A new cooperative agreement will probably include specific guidance on how the funds can be used and what activities will be supported.

Operator: And your next question comes from the line of (Tim Kenley) with Washington State Department of Health.

(Tim Kenley): Yes. Thank you. My other question is the original document for the HHS guidance that the CDC reviewed for the need of determination would be 60 days. In today’s presentation, it was stated that it would be 30 days. So, I am just asking for clarification on it. Is the review process 60 days or is it 30 days?

John Brooks: We are going to do it as fast as we can. It could have – this is an important need and we intend to do it within 30 days more or less.

(Tim Kenley): OK. Thank you.

John Brooks: You bet.

Operator: Once again, ladies and gentlemen, if you would like to register for an audio question, please press star, one.

There are no further question at this time. I would now like to turn the call back over to you.

Gabriela Paz-Bailey: Thank you.

I'm sorry – I'm sorry. And we do have a question from the line of (Gail Black) with the Department of Mental Health.

(Gail Black): Yes. When will this webinar be available in the archive?

John Brooks: In about one to two weeks, (Gail).

(Gail Black): OK. Thank you.

Operator: And your next question comes from the line of (Mary Levin) with the Georgia University School of Medicine.

(Mary Levin): Hi. This is (Mary Levin) from (Georgia) University School of Medicine. I have two questions. One is can a local health department submit a request on behalf of the entire state if that department includes information from various jurisdictions? I ask this because, sometimes, a local health department may be more nimble to submit this information – to gather and submit this information than a large state health department might be able to.

John Brooks: So, let me just clarify. You are saying if there is a state with a couple of counties and one county is a lot faster, could that county apply independently of the state?

(Mary Levin): No. What I am asking is can a county apply on behalf of the state using information from various counties?

John Brooks: Well, that would have to be with the state's cooperation, you know. And that would have – we would – it doesn't have to – I mean, it's possible that a county may say "We want to do this for the whole state." But, I think, we would have – we would (inaudible) – we would have to bring in the state leadership and the department of public health so that they are aware of that request.

(Mary Levin): OK. And ...

John Brooks: And it's very kind of a county to do that on behalf of that state.

(Mary Levin): Yes. I think – my impression is that there are some localities that are really (inaudible) (at the bit). They really like it started as soon as possible in their multiple jurisdictions. And, so, for them, if they can apply together, that would be more – that might be more feasible. But, it sounds like they should just go ahead and apply individually.

John Brooks: Actually, we would recommend that – in the long run, taking the time to apply once as a large jurisdiction, I think, is going to be well worth the effort. There is not a lot of – you know, at least with CDC, if you look at our guidance – or, as I understand that went out today among the programs that we fund, there really aren't all that many where federal funds from CDC's coffers can be used right now for SSPs.

(Mary Levin): Yes.

John Brooks: I don't know that there is so much money on the table right now that did an urgency in most places to get this done. It is going to take some time and we are all obviously trying to work as quickly and together as we can. That being said, I think, taking the time for a one-time as large a jurisdiction as possible application is going to be the better solution.

(Mary Levin): OK. And in terms of gathering data, is it OK for people to use (aids.org) or the CDC (Atlas) Web Site?

John Brooks: Sure.

(Mary Levin): OK. Great.

Operator: And, at this time, there are no audio questions.

Gabriela Paz-Bailey: So, while we get more questions, maybe we can go through some of the ones we received through the chat.

So, one from (Holly) – “(With funded program) states or counties are currently providing SSP services, do they need to submit a new request?”  
And, again, the SSP services are supported by local funds or by private funds – this guidance doesn’t apply. It’s only if you want to use federal funds to support SSP services that you would need to submit a request for concurrence from CDC on the determination of need.

John Brooks: That is right. This doesn’t affect existing SSPs that are operating legally within local jurisdictions like states. It only applies to if an existing or a new program wants to use federal funds as part of that program.

Gabriela Paz-Bailey: Another question is “Will a new request need to be submitted after one year or within a particular duration?” And, again, there is no expiration date for the determination of need. So, you wouldn’t need to resubmit for that.

Do – we have a question here – “Are Ryan White Part A funds distributed through HRSA eligible to be repurposed for SSPs?” And for this, you would need to consult to HRSA-specific guidance and they will probably spell out there what type of funds can be used.

John Brooks: They might – they might want to just go right to their HRSA project officer, and that person can find out.

Gabriela Paz-Bailey: Yes. That is a very good point. Also, you can consult with your project officer.

So, there is a question here about local health department being able to apply for a determination of need or do you have to wait for the state. And, again, it’s – we can receive applications for either local health departments or state health departments. But, we really suggest that you coordinate, as John just explained.

John Brooks: And, operator, I just – if our – if James Bethea is on. I see that we have someone with a hand raised. I am not sure what that means. But, maybe the operator can help us here if that person is trying to ask a question.



Operator: If you are trying to ask a question in – with the audio portion, please press star, one.

Gabriela Paz-Bailey: There is another question. “Are there plans to create a Web Site, perhaps on the CDC Web Site, identifying areas that have been approved?”

John Brooks: That is a great idea. I was thinking about that this morning, actually. We haven’t – that is not in our current plan. But, it would certainly be very useful to programs and local and state health departments to be able to see “Am I already covered? Do I have to go to my health department and see if I can get a determination of need made?”

Gabriela Paz-Bailey: A similar question is “Will the point of contact for each state health department be shared publicly on the CDC Web Site?” And I think that we are gathering that information right now. But, we would need to ...

John Brooks: Yes. We are going to have to see what the states what to do.

Gabriela Paz-Bailey: Yes.

John Brooks: But, certainly, e-mailing us at that mailbox that is on here SSP – you can go back, Gabriela, at that slide so folks can see it (point to). Double click, maybe. No. Right. There we go. That Web Site – just – if you send us a question, that is where we will – we can begin to try and correspond with you to identify the right point of contact.

Gabriela Paz-Bailey: Another question is “Generally, for how many or what percentage of jurisdictions would data need to be presented for a statewide determination?”

John Brooks: It is not – you know, it’s on a – it’s on a state-by- state basis. I mean, if there is a – if there is compelling evidence that there are, let’s say, as few as two jurisdictions in a state but they’ve got a big problem and you have reason to believe that it could spread outside of that area, if you write a compelling argument, we may see fit to concur with that.

And if not, we will get back – we will respond saying, “Listen. Could you provide – we would recommend additional evidence here if you can get it.”

We – once a determination or a request for a determination has been submitted, we will be working with those submitters, if necessary, to try and make them strong as possible if they are not adequately (as we receive them).

Gabriela Paz-Bailey: Thank you, John.

We have another question here. “How long do you anticipate the approval process will take?” And we – and the determination of need would be reviewed and you will get a response within 30 days.

John Brooks: Right. And that response may be either we concur or we don’t concur or we want additional information.

Gabriela Paz-Bailey: So – yes. There are some questions about needing to resubmit, that we already said that it doesn’t have an expiration date.

There is a question here from (Rene Sterling). “If an organization is implementing SSP right now excluding needle exchange and using federal funds, is that (a problem)?” Perhaps they started several years. And I think it is the case that HIV testing and hepatitis testing may be already supported with current funds.

John Brooks: Yes. I mean, there may be things that are, for one reason or another, are already being supported by federal funds with the way the law has changed a few times in the past. But, going forward from this, any new federal funds or redirection of existing federal funds would have to take place under a determination of need having been established first.

Gabriela Paz-Bailey: Yes. So, if current (programs) have been approved for certain activities, you probably don’t need to worry about it. It’s more if you want to add for permission to redirect funds.

(off-mic)

John Brooks: Right. And I see that some of them is asking who is the IHS person we are working with. It’s Lisa Neel – N-E-E-L. I don’t know if she may be on the call today.

Operator: Operator, do we have any more questions?

John Brooks: Hi, Lisa. I see you there. OK.

Operator: And we do have another question. And your question comes from the line of John Melichar with San Francisco Department of Public Health.

John Melichar: Yes. Hi. Thank you for this. And about time that this is happening. We are sorry that with this – we work with CDC funds here at – the (1201) grant in my office. And we were encouraged a few years back with a false start. But, we are happy to see it happening now.

So, from my understanding, it is that we are looking at – this call is primarily about the determination of need and that this person, this SSP coordinator, is going to be really routing that process. So, I guess, I am looking bit further down the road. Will it be up to the individual funding streams to do the monitoring and evaluation on these programs that they are funded?

John Brooks: Well, I don't know about – specifically about monitoring and evaluation. But, it will be up to the project officers who are administering each funding stream, whether it's a grant, a cooperative agreement, however it is going out. It will be up to the project officer to work with the funded jurisdiction to ensure that, one, the funds are being used in the – in the way that is permitted under each agency's guidance – and for CDC, that went out this morning – and, then, to perform any monitoring and evaluation that is required under that guidance.

John Melichar: I guess, one thing that would be – would be nice is if there were some sort of coordination in terms of what we should be looking at in terms of data collection so that we don't have different requirements from different funding sources and that – I mean, even if – different is probably better than similar but not exactly the same.

John Brooks: Yes. I see. I see. Yes. That is a good point. And, right now, we are – you know, in the effort to move quickly forward, we – there are things like this that we will probably have to consider on the fly as we get there. But, at the – I think, as in the past, it's hard to anticipate where that – where those differences may lie. But, folks from – like you in the field, when you bring it

to our attention quickly, we will do our best to try and reconcile them and simplify the process for everyone involved. We hate to be burdensome if we don't have to be.

John Melichar: Sure. And it's just – and a set of data collection tools that, you know – that's coordinated would be really helpful.

John Brooks: OK. That is good to know. Thanks.

Operator: And your next question comes from the line of (Filomena Quebec):, (Ben River Needle Executive).

(Filomena Quebec): Hi. This is (Filomena Quebec). I am at the (Ben River Needle). I was just – I was just wondering if you have contact information for Lisa Neal. I'm not sure ...

John Brooks: Sure. And it's Lisa Neel – N-E-E-L. And she is with the Indian Health Service. And Lisa's e-mail address, which I am hoping I will be able to find for you very quickly. She is – here, she is typing it in. All right, Lisa. Phone line are open at 301-443-4305. I will repeat that – 301-443-4305. She has also typed it into the chat. And it's [lisa.neel@ihs.gov](mailto:lisa.neel@ihs.gov).

(Filomena Quebec): Thank you.

John Brooks: Sure.

Gabriela Paz-Bailey: And ...

Operator: Once again, ladies and gentlemen, if you would like to register for an audio question, please press star, one.

Gabriela Paz-Bailey: Thank you, operator.

In the meantime, I am going to read another question from the chat. "Hello. This is (Mary Anne) from (CTDTH). Is there a template to submit the request or do we just compile the data sources using the appendix provided?" So, there is no form. But, you can use the appendix provided as a way to organize your data and present it.

John Brooks: I mean, that – we don't have a – we don't have a template online other than the example table that is in that appendix. Yes.

Operator, any further questions?

Operator: At this time, there are no audio questions.

John Brooks: We will hang on for a second and give folks a chance to think (and type one on their phone). My phone – (I've got it new. I can't find it).

(off-mic)

John Brooks: I know. I would be hopeless (and – that new phone is terrible. Yes).

OK. Well, we've got – I think – (what are we) – 3:25, Gabriela?

Gabriela Paz-Bailey: That is correct, John – 3:26.

So, I was just – there was a question about non-injection drug use that I am trying to find. ...

John Brooks: Someone here has reminded me that agency-specific guidance can be found through the [aids.gov](http://aids.gov) or [hhs.gov](http://hhs.gov) Web Site.

Gabriela Paz-Bailey: We will be making the slides available ...

John Brooks: Yes. One to two weeks.

Gabriela Paz-Bailey: ... at the CDC Web Site. Right?

Well, we thank very much everyone for participating. Your questions have been very, very helpful to clarify several points. So, thank you so much. And we are looking forward to receiving those requests for determination of need at CDC.

Operator: Ladies and gentlemen, that does conclude the webinar call for today. We thank you for your participation and ask that you please disconnect your lines.

Presenters, please hold.

One again, ladies and gentlemen, thank you for your participation in today's conference. You may now disconnect.

END