**PS20-2010 Ending the HIV Epidemic**

**Evaluation and Performance Measurement Plan (EPMP) and Work Plan: Component A**

**Name of Jurisdiction/Agency Submitting Plan**: Click to enter text.

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**Project Period**: TBD

**Last Updated Date**: Click to enter a date.

**Version 1.1 (February 6, 2020)**

Note: PS20-2010 EPMP Version 1.0 applies to Component A and should not be completed for Component B or Component C.

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# **Program Description** – **Component A**

## Section 1: Logic Model – Component A

Please provide a logic model for PS20-2010 Component A that reflects the relationships between your project’s strategies and outcomes.

**Note**: You may adopt the CDC logic model (refer to Appendix A) for your local PS20-2010 program without modification. However, if you wish to include other outcomes not listed in the CDC logic model, please do so below. **Section 1 need not be completed if the jurisdiction has adopted the CDC** **logic model – Component A (Appendix A).**

Table 1

| **PS20-2010 Logic Model – Ending the HIV Epidemic** | | | | |
| --- | --- | --- | --- | --- |
| **Strategy: From Appendix A Logic Model** | | **Short-Term Outcome** | **Intermediate Outcome** | **Long-Term Outcome** |
| **Diagnose** |  |  |  |  |
| **Treat** |  |  |  |  |
| **Prevent** |  |  |  |  |
| **Respond** |  |  |  |  |

## Section 2: Program Activities – Component A

In the tables below, please provide a description of the program activities to be implemented under PS20-2010. Activities described in this section should align with the strategies and outcomes noted in the logic model provided in Appendix A (and Section 1, if applicable). Your description for Year 1 should be a summary and should convey enough detail to ensure the understanding of program goals and activities (note: this should not be a copy/paste of program activities from the application.) Your description of Year 2-5 should be high-level summary of the activities.

**Note:** If you need assistance, please contact your PS20-2010 CDC Joint Monitoring Team (JMT).

Table 2

| **Diagnose** | | |
| --- | --- | --- |
| **Strategy** | **Activity** | |
| **Year 1** | **Year 2-5** |
| **Strategy 1A.** Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities |  |  |
| **Strategy 1B.** Develop locally-tailored HIV testing programs to reach persons in non- healthcare settings |  |  |
| **Strategy 1C.** Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings |  |  |

Table 3

| **Treat** | | |
| --- | --- | --- |
| **Strategy** | **Activity** | |
| **Year 1** | **Year 2-5** |
| **Strategy 2A.** Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV |  |  |
| **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP) |  |  |

Table 4

| **Prevent** | | |
| --- | --- | --- |
| **Strategy** | **Activity** | |
| **Year 1** | **Year 2-5** |
| **Strategy 3A.** Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP |  |  |
| **Strategy 3B.** Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs) |  |  |

Table 5

| **Respond** | | |
| --- | --- | --- |
| **Strategy** | **Activity** | |
| **Year 1** | **Year 2-5** |
| **Strategy 4A.** Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response |  |  |
| **Strategy 4B. I**nvestigate and intervene in networks with active transmission |  |  |
| **Strategy 4C.** Identify and address gaps in programs and services revealed by cluster detection and response |  |  |

## Section 3: Priority Populations – Component A

Please describe below, 1) 3-5 populations you will prioritize to receive HIV prevention services under your PS20-2010 program, 2) the needs identified for each population listed, and 3) the program strategies and activities planned to address the identified needs. The priority populations described should be congruent with those identified in your integrated care and prevention plan. Please only describe priority and target populations for PS20-2010.

Note: In column 4, when describing strategies, you may reference strategies by their number and letter (e.g., 1A, 1B, etc.)

Table 6

| **Priority and Target Populations** | | | |
| --- | --- | --- | --- |
| **Priority Population** | **Identification in Integrated Care and Prevention Plan (i.e., page numbers)** | **Identified Need** | **Primary Strategies & Activities to Address Need** |
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# **Jurisdiction Evaluation Plan** – **Component A**

## Section 4: Proposed Activities and Indicators

The activities listed below are examples of what your program may opt to perform. The indicators and specifications provided are recommended to be used if your program elects to perform one or more of the activities described below. However, you may also suggest an alternative indicator for any of the activities below. To do so, please indicate the activity, indicator, specification and how the data will be reported to CDC in the empty rows under each strategy section (additional rows may be added).

Additionally, if your program is performing activities that are not listed below, please indicate the activity, indicator, specification and how the data will be reported to CDC in the empty rows under each strategy section (additional rows may be added).

Note: Under Respond, all indicators are required and should be reported to CDC.

Table 7

| **Diagnose** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **PS20-2010 Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States of America** | | | | | |
| **Activity** | | **Indicator** | **Specification** | **Data Reported to CDC** | |
|  | Not Activity Specific | Percentage of people with HIV >= 13 years old who know their serostatus (EHE target: at least 95% by 2025) | CDC calculated | | NHSS |
| **Strategy 1A:** **Expand or implement routine opt-out HIV screening in healthcare and other institutional settings located in high prevalence communities**. | | | | | |
|  | 1A.1. Identify and select health care facilities that have not already implemented routine HIV screening and automate HIV test orders for eligible patients. | Percentage of health care facilities identified as priority for routine opt-out HIV screening | **Numerator**: Number of health care facilities in the denominator that have established an on-site champion for implementation | Local HD data through APR  Frequency: Annual | |
| **Denominator:** Number of health care facilities identified as priority for routine opt-out HIV screening |
| Percentage of HIV tests conducted in healthcare facilities identified as a priority for the EHE testing services | **Numerator**: Number of tests in the denominator that were conducted in healthcare facilities identified as a priority for EHE testing services | Local HD data through APR  Frequency: Annual | |
| **Denominator:** Number of HIV tests conducted in health care facilities |
| Percentage of persons tested in health care facilities identified as priority for routine opt-out screening | **Numerator**: Number of persons in the denominator who were tested for HIV during the reporting period | NHM&E  Frequency: Bi-annual | |
| **Denominator:** Number of persons identified as priority for routine opt-out screening during the reporting period |
|  | 1A.2 Promote routine opt-out HIV screening as a part of medical intake in jails located in high prevalence communities. | Percentage of persons incarcerated in large county jails who were tested for HIV. | **Numerator:**  Number of persons in the denominator who were tested for HIV during the reporting period | Local HD data through APR  Frequency: Annual | |
| **Denominator:**  Number of persons incarcerated in large county jails during the reporting period |
|  | 1A.3. Identify “champions” or key staff (e.g. nurses/other medical staff performing intake medical examinations) to lead activities to routinize HIV screening at intake. | Number of “champions” or key staff leading activities to routinize HIV screening at intake per project year. | **Count:**  Number of “champions” or key staff leading activities to routinize HIV screening at intake per project year | Local HD data through APR  Frequency: Annual | |
|  | 1A.4. Modify the electronic medical records to routinize the offer of screening and screen all patients (at least once) for HIV regardless of risk. | Percentage of health facilities that modified the electronic medical records to routinize the offer of screening and screen all patients | **Numerator:** Number of health care facilities in the denominator that modified the electronic medical records to screen all patients | Local HD data through APR  Frequency: Annual | |
| **Denominator:** Number of health care facilities identified as priority for routine opt-out HIV screening |
|  | 1A.5. Establish mechanisms for rapid linkage to HIV medical care and prevention (i.e., PrEP and SSP) services for persons screened for HIV in all healthcare settings. | Documentation of mechanisms for rapid linkage to HIV medical care and prevention (i.e., PrEP and SSP) services for persons screened for HIV in all healthcare settings. | Documentation of mechanisms for rapid linkage to HIV medical care and prevention (i.e., PrEP and SSP) services for persons screened for HIV in all healthcare settings | Local HD data through APR  Frequency: Annual | |
| Percentage of all persons tested linked to HIV medical care | **Numerator:** Number of persons in the denominator linked to HIV medical care | Local HD data through APR or NHM&E  Frequency: Annual (APR) or semi-annual (NHM&E March and September) | |
| **Denominator:** Number of persons who tested HIV positive during the reporting period |
| Percentage of all persons tested linked to appropriate prevention services | **Numerator:** Number of persons in the denominator linked to appropriate prevention services | Local HD data through APR or NHM&E  Frequency: Annual (APR) or semi-annual (NHM&E March and September) | |
| **Denominator:** Number of persons who tested HIV positive during the reporting period |
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| **Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings.** | | | | | |
|  | 1B.1 Advertise broadly and provide residents multiple options to receive HIV tests in venues that do not traditionally promote tests. | Number of non-traditional venues conducting HIV testing. | **Count:**  Number of non-traditional venues conducting HIV testing | Local HD data through APR  Frequency: Annual | |
| Percentage of HIV tests conducted in non-traditional venues identified as a priority for the EHE testing services | **Numerator**: Number of tests in the denominator that were conducted in non-traditional venues identified as a priority for EHE testing services |
| **Denominator:** Number of HIV tests conducted in non-healthcare settings |
|  | 1B.2. Promote rapid HIV self-test distribution programs, mobile testing units, technology-based partner services and social network strategies. | Number of HIV self-test kits distribution events planned | **Count:**  Number of HIV self-test kits distributions planned | Local HD data through APR  Frequency: Annual | |
|  | 1B.3. Implement testing at health fairs or pop-up testing events whereby HIV testing is offered as a service bundled with screening for other conditions relevant to the local population (e.g., STD testing, blood pressure screening, BMI assessment). | Number of events where HIV testing is bundled with screening for other conditions relevant to the local population. | **Count:**  Number of events where HIV testing is bundled with screening for other conditions relevant to the local population | Local HD data through APR  Frequency: Annual | |
|  | 1B.4. Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings. | Documentation of incorporating strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings. | Documentation of incorporating strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings | Local HD data through APR  Frequency: Annual | |
| Percentage of all persons tested in non-traditional test settings linked to medical care within 30 days | **Numerator:** Number of persons in the denominator linked to HIV medical care | Local HD data through APR or NHM&E  Frequency: Annual (APR) or semi-annual (NHM&E March and September) | |
| **Denominator:** Number of persons who tested HIV positive during the reporting period |
| Percentage of all persons tested in non-traditional test settings linked to appropriate prevention services | **Numerator:** Number of persons in the denominator linked to appropriate prevention services | Local HD data through APR or NHM&E  Frequency: Annual (APR) or semi-annual (NHM&E March and September) | |
| **Denominator:** Number of persons who tested HIV positive during the reporting period |
|  | 1B.5. Collaborate with laboratories to determine appropriate tests and improve the quality of testing in non-healthcare settings. | Documentation of collaboration with laboratories to determine appropriate tests and improve the quality of testing in non-healthcare settings. | Documentation of collaboration with laboratories to determine appropriate tests and improve the quality of testing in non-healthcare settings | Local HD data through APR  Frequency: Annual | |
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| **Strategy 1C:**  **Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings.** | | | | | |
|  | 1C.1. Establish systems whereby patients with elevated risk are routinely identified and HIV tests are ordered at least yearly. In some settings, annual screening of all patients could be considered. | Documentation of establishing systems whereby patients with elevated risk are routinely identified and HIV tests are ordered at least yearly. | Documentation of establishing systems whereby patients with elevated risk are routinely identified and HIV tests are ordered at least yearly | Local HD data through APR  Frequency: Annual | |
|  | 1C.2. Identify “champions” (e.g., physicians, nurses, etc.) who can lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population | Number of “champions” who lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population | **Count:**  Number of “champions” who lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population | Local HD data through APR  Frequency: Annual | |
|  | 1C.3. Modify the electronic medical records to routinize the offer of annual screening for those at ongoing risk for HIV. | Number of facilities with modified electronic medical records to routinize the offer of annual screening for those at ongoing risk for HIV. | **Count:**  Number of facilities with modified electronic medical records to routinize the offer of annual screening for those at ongoing risk for HIV | Local HD data through APR  Frequency: Annual | |
|  | 1C.4. Promote rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk. This could include self-tests that clients can take away for themselves or distribute to others in their network. | Documentation of promoting rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk. | Documentation of promoting rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk | Local HD data through APR  Frequency: Annual | |
| **Count:**  Number of self-tests distributed |
|  | 1C.5. Identify novel approaches to make HIV tests widely available in non-healthcare settings where marginalized populations, including people experiencing homelessness and/or those injecting drugs, congregate (e.g., homeless shelters mobile clinics and laboratories, and SSPs). | Documentation of novel approaches to make HIV tests widely available in non-healthcare settings where marginalized populations, including people experiencing homelessness and/or those injecting drugs, congregate. | Documentation of novel approaches to make HIV tests widely available in non-healthcare settings where marginalized populations, including people experiencing homelessness and/or those injecting drugs, congregate. | Local HD data through APR  Frequency: Annual | |
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| **Treat** | | | | |
| --- | --- | --- | --- | --- |
| **PS20-2010 Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States of America** | | | | |
| **Activity** | | **Indicator** | **Specification** | **Data Reported to CDC** |
| **Strategy 2A.** **Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV.** | | | | |
|  | 2A.1 Develop a robust network (supported by interagency/facility agreements) for rapid linkage to clinical care and essential support services. | Percent linked to HIV care within 1 month after diagnosis among persons aged >= 13 years old with newly diagnosed HIV infection during the measurement period. | **Numerator:** The number of newly HIV diagnosed persons linked to HIV care within 1 month of diagnosis | NHSS or NHM&E  (for CDC-funded linkage)  Frequency: Semi-Annual (NHM&E: March and September) |
| **Denominator:** Number of persons >=13 years of age who have been newly diagnosed with HIV in the measurement period |
| Percentage of persons >=13 years living with diagnosed HIV who received any HIV medical care as measured by documentation of >=1 CD4 or viral load tests performed during the measurement period (EHE target: 95% by 2025). | **Numerator:**  Number of persons in the denominator who are in HIV medical care as measured by documentation of >=1 CD4 or viral load tests performed during the measurement period | NHSS |
| **Denominator:**  Number of persons >=13 years of age living with diagnosed HIV during the measurement period |
| Percentage of persons >=13 years of age with HIV diagnosed in the measurement period and with viral suppression <= 6 months after HIV diagnosis (EHE target: at least 95% by 2025). | **Numerator:**  Number of persons in the denominator who became virally suppressed (HIV RNA undetectable or < 200 copies/mL) <= 6 months after HIV diagnosis |
| **Denominator:**  Number of persons >=13 years of age who have been diagnosed with HIV in the measurement period |
| Percentage of persons >=13 years of age living with diagnosed HIV who are virally suppressed at last test (prevalence-based viral suppression) (EHE target: 90% by 2025). | **Numerator:**  Number of persons in the denominator who were virally suppressed (HIV RNA undetectable or < 200 copies/mL) at last test |
| **Denominator:**  Number of persons >=13 years of age who have been diagnosed with HIV in the jurisdiction |
| Percentage of presumptively not-in-care PWH with an investigation opened (initiated) during a specified 6-month evaluation time period, who were confirmed within 90 days after the investigation was opened not to be in care. | **Numerator:**  Of those in the denominator, the number confirmed within 90 days after the investigation was opened not to be in care |
| **Denominator:**  Number of presumptively not-in-care PWH with an investigation opened (initiated) during a specified 6-month evaluation time period |
| Percentage of PWH confirmed during a specified 6-month evaluation time period not to be in care, who were linked to HIV medical care within 30 days after being confirmed not to be in care. | **Numerator:**  Of those in the denominator, the number linked to HIV medical care within 30 days as measured by documentation of CD4 or viral load after being confirmed not to be in care |
| **Denominator:**  Number of PWH confirmed during a specified 6-month evaluation time period not to be in care |
| Percentage of PWH linked to HIV medical care during a specified 6- month evaluation time period, who achieved HIV viral suppression within six months (180 days) after being linked to care. | **Numerator:**  Of those in the denominator, the number who achieved HIV viral suppression within six months (180 days) after being linked to care |
| **Denominator:**  Number of PWH linked to HIV medical care during a specified 6- month evaluation time period |
|  | 2A.2. Establish or expand secure electronic methods or on-call hotlines(s) to report all new HIV diagnoses to health department in real-time, in accordance with state and local policy. | Percentage of all new HIV diagnoses reported to health department in real-time, in accordance with state and local policy. | **Numerator: O**f those in the denominator, those new HIV diagnoses that were reported in real time | NHSS  Frequency: Semi-Annual (June and December) |
| **Denominator:** Number of all new HIV diagnoses in reporting period |
|  | 2A.3. Conduct a rapid needs assessment (housing, transportation etc.) for all persons with new HIV diagnoses and link to a disease intervention specialist and/or case manager as needed. | Percentage of all persons with a new HIV diagnosis where a rapid needs assessment was conducted. | **Numerator:** Of those in the denominator, the number who had a rapid needs assessment conducted | Local HD data through APR  Frequency: Annual |
| **Denominator:** Number of all new HIV diagnoses in reporting period |
| Percentage of all persons with a needs assessment conducted who were linked to a disease intervention specialist and/or case manager as needed. | **Numerator:** Of those in the denominator, the number of persons linked to a disease intervention specialist and/or case manager as needed |
| **Denominator:** Number who had a rapid needs assessment conducted with indication for linkage to a disease intervention specialist and/or case manager |
|  | 2A.4. Develop programs to support and promote rapid linkage and early ART initiation by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities. | Documentation of programs developed to support and promote rapid linkage and immediate ART initiation (or as soon as possible) by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities. | Documentation of programs developed to support and promote rapid linkage and immediate ART initiation (or as soon as possible) by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities | Local HD data through APR  Frequency: Annual |
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|  |  |  |  |  |
|  |  |  |  |  |
| **Strategy 2B:** **Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program facilities.** | | | | |
| **Activity** | | **Indicator** | **Specification** | **Data**  **Reported to CDC** |
|  | 2B.1. Develop, expand and scale up Data to Care programs using surveillance data and other data sources to identify patients not in care (e.g. within 30 days of missed ART pick-up) and develop re-engagement strategies (e.g. utilizing linkage specialists, disease intervention specialists). | Documentation of the development, expansion and scale up of Data to Care programs using surveillance data and other data sources to identify patients not in care (e.g. within 30 days of missed ART pick-up) and develop re-engagement strategies (e.g. utilizing linkage specialists, disease intervention specialists). | Documentation of the development, expansion and scale up of Data to Care programs using surveillance data and other data sources to identify patients not in care (e.g. within 30 days of missed ART pick-up) and develop re-engagement strategies (e.g. utilizing linkage specialists, disease intervention specialists) | Local HD data through APR  Frequency: Annual |
|  | 2B.2. Develop electronic based approaches (e.g., text messaging, virtual case management) to support retention in care activities, patient navigation and distribution of strengths-based case management (e.g., ARTAS) via phone. | Documentation of electronic based approaches (e.g., text messaging, virtual case management) to support retention in care activities, patient navigation and distribution of strengths-based case management (e.g., ARTAS) via phone. | Documentation of electronic based approaches (e.g., text messaging, virtual case management) to support retention in care activities, patient navigation and distribution of strengths-based case management (e.g., ARTAS) via phone | Local HD data through APR  Frequency: Annual |
|  | 2B.3. Create and maintain an easily accessible provider-initiated retention in care support service (e.g., encrypted online reporting system) for providers to request health department support when patients miss appointments or appear to be lost to follow up. | Documentation of provider-initiated retention in care support service (e.g., encrypted online reporting system) for providers to request health department support when patients miss appointments or appear to be lost to follow-up. | Documentation of provider-initiated retention in care support service (e.g., encrypted online reporting system) for providers to request health department support when patients miss appointments or appear to be lost to follow | Local HD data through APR  Frequency: Annual |
|  | 2B.4.Provide locally informed, evidence-based incentives (non-monetary) to PWH for retention in care and viral suppression. | Documentation of providing locally informed, evidence-based incentives (non-monetary) to PWH for retention in care and viral suppression. | Documentation of providing locally informed, evidence-based incentives (non-monetary) to PWH for retention in care and viral suppression | Local HD data through APR  Frequency: Annual |
|  | 2B.5. Develop robust telemedicine programs that use electronic information and telecommunications technologies to support and promote long-distance clinical health care and patient health-related education. Please reference the *Other Information* section for additional resources specific to telemedicine. | Documentation of the development of robust telemedicine programs that use electronic information and telecommunications technologies to support and promote long-distance clinical health care and patient health-related education. | Documentation of the development of robust telemedicine programs that use electronic information and telecommunications technologies to support and promote long-distance clinical health care and patient health-related education | Local HD data through APR  Frequency: Annual |
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| **PREVENT** |
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| **PS20-2010 Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States of America** |

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| --- | --- | --- | --- | --- |
| **Activity** | | **Indicator** | **Specification** | **Data Reported to CDC** |
| **Strategy 3A: Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.** | | | | |
|  | 3A.1.Support development and delivery of PrEP services in clinical and nonclinical sites in communities with the highest rates of new HIV diagnoses. | Percent of persons hired as PrEP detailers. | **Numerator:**  Number of persons hired as PrEP detailers. | Local HD data through APR  Frequency: Annual |
| **Denominator:**  Number of positions in the health department budget for PrEP detailers. |
| Number and percentage of clinicians prescribing PrEP within 3 months following detailing visit(s). | **Numerator:**  Number of clinicians in the denominator prescribing PrEP within 3 months of a detailing visit. | Local HD data through APR  Frequency: Annual |
| **Denominator:**  Number of clinicians provided detailing visit(s) for PrEP |
| Number of HIV-negative clients who are screened for PrEP | **Count:**  Number of HIV-negative clients who are screened for PrEP | Local HD data through APR  Frequency: Annual |
| Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP | **Count:**  Number of HIV-negative clients with indications for PrEP who are linked to PrEP | Local HD data through APR  Frequency: Annual |
| **Numerator:**  Number of HIV-negative clients in the denominator who are linked to PrEP |
| **Denominator:**  Number of HIV-negative clients with indications for PrEP |
| Number of persons prescribed PrEP among those with indications for PrEP | **Count:**  Number of persons prescribed PrEP among those with indications for PrEP | Local HD data through APR  Frequency: Annual |
| Percent of persons using PrEP (defined as filling prescriptions) among those with indicators for PrEP (EHE target: at least 50% by 2025) | **CDC calculated** | TBD |
|  | 3A.2. Increase PrEP training among private and safety-net clinical providers by increasing the number of trained PrEP detailers through collaboration with organizations that have demonstrated success in providing ongoing training and support and adapting resources from CDC and others to meet local provider training needs. | Number of newly trained PrEP detailers. | **Count:**  Number of newly trained PrEP detailers | Local HD data through APR  Frequency: Annual |
|  | 3A.3. Provide training and technical assistance to non-clinical CBOs that provide HIV testing services to screen clients for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs). | Documentation of trainings and provision of technical assistance to non-clinical CBOs that provide HIV testing services to screen clients for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs). | Documentation of trainings and provision of technical assistance to non-clinical CBOs that provide HIV testing services to screen clients for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs) | Local HD data through APR  Frequency: Annual |
| Number of non-clinical CBO staff provided trainings or TA on PrEP screening and linkage | **Count:**  Number of staff provided trainings or TA on PrEP screening and linkage at non-clinical CBOs |
|  | 3A.4.Incentivize PrEP provision that is appropriate to locally specific demographics of persons with new HIV diagnoses while maintaining provision of PrEP to all persons with indications for its use. | Number and type of incentives decided upon by the health department | **Count:**  Number and type of incentives decided upon by the health department | Local HD data through APR  Frequency: Annual |
|  | 3A.5. Support the formation of a locally-driven peer network of African American and Hispanic/Latino persons who are PrEP users, to educate on PrEP and support PrEP uptake and continued PrEP use among persons in their social networks. | Number of African American PrEP users engaged to educate and provide support for PrEP uptake and use | **Count:**  Number of African American PrEP users engaged to educate and provide support for PrEP uptake and use | Local HD data through APR  Frequency: Annual |
| Number of Hispanic/Latino PrEP users engaged to educate and provide support for PrEP uptake and use | **Count:**  Number of Hispanic/Latino PrEP users engaged to educate and provide support for PrEP uptake and use |
|  | 3A.6.Develop and implement locally-specific insurance and cost-assistance navigation protocols for PrEP patients. | Documentation of implementation of locally-specific insurance and cost-assistance navigation protocols for PrEP patients. | Documentation of implementation of locally-specific insurance and cost-assistance navigation protocols for PrEP patients | Local HD data through APR  Frequency: Annual |
|  | 3A.7.Support client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems. This may include active referral and linkage to: home test kits for some visits, PrEP care in community pharmacies, and use of telemedicine services especially in rural communities. | Documentation of supporting client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems. | Documentation of supporting client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems | Local HD data through APR  Frequency: Annual |
|  | 3A.8.Disseminate approaches proven effective to support adherence and persistence. Examples include certified health coaches or nurse educators, certified community health workers, PrEP navigators, use of eHealth technology, and pharmacist- based PrEP services. Priority should be given to services that are fiscally sustainable | Documentation of disseminating approaches proven effective to support adherence and persistence. | Documentation of disseminating approaches proven effective to support adherence and persistence | Local HD data through APR  Frequency: Annual |
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| **Strategy 3B – Increase availability, use, and, access to and quality of comprehensive Syringe Services Programs (SSPs).** | | | | |
|  | 3B.1. Ensure that SSPs provide clients with the following standard services: needs-based access to sterile needles and syringes and other injection equipment (e.g., sterile water, cookers), condoms, syringe disposal, HIV and HCV testing, linkage to HIV and HCV care, linkage to PrEP, naloxone distribution, and linkage to medication-assisted treatment. | Number of SSPs offering standard services | **Count:**  Number of SSPs offering standard services | Local HD data through APR  Frequency: Annual |
| Percentage of SSPs offering standard services | **Numerator:**  Of those in the denominator, the number offering standard services |
| **Denominator:**  Number of SSPs offered in the jurisdiction |
|  | 3B.2. Condom distribution efforts, including the promotion of and provision of condoms, within communities, venues, and other settings, should be included as a component of the SSPs. | Number of SSPs with condom distribution services | **Count:**  Number of SSPs with condom distribution services | Local HD data through APR  Frequency: Annual |
| Percentage of SSPs with condom distribution services | **Numerator:**  Of those in the denominator, the number of SSPs with condom distribution services |
| **Denominator:**  Number of SSPs offered in the jurisdiction |
|  | 3B.3. Ensure that SSPs have the following additional services provided directly to clients or available through formal, active referral arrangements facilitated by patient navigators   * + Infectious disease prevention, detection, care, and treatment; including HIV, viral hepatitis (HAV, HBV, and HCV), sexually transmitted infections (syphilis, gonorrhea, and chlamydia) and wound care.   + Substance use disorder care and treatment; including low threshold medication-assisted treatment and evidence-based psychological and behavioral treatments (e.g., talk therapies).   + Essential support services, including housing, transportation; mental health/substance use counseling. | Number of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment | **Count:**  Number of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment | Local HD data through APR  Frequency: Annual |
| Percentage of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment | **Numerator:**  Of those in the denominator, the number of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment |
| **Denominator:**  Number of SSPs offered in the jurisdiction |
| Number of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment | **Count:**  Number of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment |
| Percentage of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment | **Numerator:**  Of those in the denominator, the number of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment |
| **Denominator:**  Number of SSPs offered in the jurisdiction |
| Number of SSPs with direct provision of or formal active referral arrangements to essential support services | **Count:**  Number of SSPs with direct provision of or formal active referral arrangements to essential support services |
| Percentage of SSPs with direct provision of or formal active referral arrangements to essential support services | **Numerator:**  Of those in the denominator, the number of SSPs with direct provision of or formal active referral arrangements to essential support services |
| **Denominator:**  Number of SSPs offered in the jurisdiction |
|  | 3B.4. Promote and establish SSPs strategically distributed across communities with the highest number of new HIV diagnoses attributed to injection drug use, highest number of new HCV diagnoses, and/or highest rates of drug overdose. | Documentation of promotion and establishment ofSSPs strategically distributed across communities | Documentation of promotion and establishment ofSSPs strategically distributed across communities | Local HD data through APR  Frequency: Annual |
| Number of encounters served by SSPs | **Count:**  Number of encounters served by SSPs | Local HD data through APR  Frequency: Annual |
|  | 3B.5. Educate the community about the availability and evidence-base of SSP services, including through the use of evidence-based consumer materials and content. | Documentation of educating the community about the availability and evidence-base of SSP services, including through the use of evidence-based consumer materials and content. | Documentation of educating the community about the availability and evidence-base of SSP services, including through the use of evidence-based consumer materials and content. | Local HD data through APR  Frequency: Annual |
|  | 3B.6. For jurisdictions that do not currently have laws in place to support SSPs, educate stakeholders about the evidence which has shown that SSPs reduce the transmission and spread of infectious diseases. | Documentation of educating stakeholders about the evidence which has shown that SSPs reduce the transmission and spread of infectious diseases. | Documentation of educating stakeholders about the evidence which has shown that SSPs reduce the transmission and spread of infectious diseases | Local HD data through APR  Frequency: Annual |
|  | 3B.7.Increase access to sterile needles and syringes for persons who inject drugs (PWID) through non-prescription syringe sales in community pharmacies, where allowed by law. | Documentation of efforts to increase access to sterile needles and syringes for persons who inject drugs (PWID) through non-prescription syringe sales in community pharmacies, where allowed by law. | Documentation of efforts to increase access to sterile needles and syringes for persons who inject drugs (PWID) through non-prescription syringe sales in community pharmacies, where allowed by law | Local HD data through APR  Frequency: Annual |
|  | 3B.8. Develop and implement a quality management program to continuously evaluate and improve SSP service delivery according to evidence-based practices defined by HHS. | Documentation of the development and implementation of a quality management program to continuously evaluate and improve SSP service delivery according to evidence-based practices defined by HHS. | Documentation of the development and implementation of a quality management program to continuously evaluate and improve SSP service delivery according to evidence-based practices defined by HHS | Local HD data through APR  Frequency: Annual |
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| **RESPOND** | | |
| --- | --- | --- |
| **PS20-2010 Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States of America** | | |
| **Indicator** | **Specification** | **Data Reported to CDC** |
| **Strategy 4A:** **Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response.**  **Strategy 4B: Investigate and intervene in networks with active HIV transmission.**  **Strategy 4C: Identify and address gaps in programs and services revealed by cluster detection and response**  **Note: All indicators are required and should be reported to CDC.** | | |
| Health departments routinely review cluster data, prioritize clusters, guide cluster response, review response data, and modify and improve responses | **Count:**  Number of meetings of standing committee to guide cluster response (at least quarterly) | Local HD data through APR  Frequency:  Annual |
| **Count:**  Number of meetings per year with a wide range of community members to engage them in cluster response (at least quarterly) |
| **Count:**  Number of agreements for external partners, such as CBOs or local health departments, to be involved in cluster response. |
| **Count:**  Number of after-action review meetings or other debriefing to evaluate outcomes and lessons learned from cluster responses |
| Of all persons with diagnosed HIV infection entered into the local surveillance system during the evaluation time period, ≥85% were entered ≤30 days after the date of diagnosis | **Numerator:**  Number of persons in the denominator entered into the local surveillance system ≤30 days after the date of diagnosis | NHSS or local HD data  Frequency: At least annual |
| **Denominator:**  Number of persons with diagnosed HIV infection residing in the jurisdiction at diagnosis that were entered into the surveillance system during the evaluation time period |
| Of all laboratory test results entered into the local surveillance system during the evaluation time period, ≥75% were entered ≤14 days after the date of specimen collection | **Numerator:**  Number of laboratory test results in the denominator that were entered ≤14 days after the date of specimen collection | NHSS or local HD data  Frequency: At least annual |
| **Denominator:**  Number of laboratory test results entered into the surveillance system during the evaluation time period |
| Develop and maintain a comprehensive data system to rapidly analyze, integrate, visualize, and share data in real time | Documentation of the development and maintenance of a comprehensive data system to rapidly analyze, integrate, visualize, and share data in real time | Local HD data through APR  Frequency: Annual |
| Develop flexible funding mechanisms to allow reallocation of resources for a response | Documentation of the development of flexible funding mechanisms to allow reallocation of resources for a response within one month | Local HD data through APR  Frequency: Annual |
| Implement methods to identify and understand the entire network | Documentation of the implementation of methods to identify and understand the entire network, including people with diagnosed HIV, undiagnosed HIV, or at high risk for HIV infection | Local HD data through APR  Frequency: Annual |
| Provide critical services to network members. | Documentation of processes and mechanisms to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people in cluster networks | Local HD data through APR  Frequency: Annual |
| Documentation of processes and mechanisms to ensure appropriate linkage to care activities (including medical and non-medical services) for PWH in networks with active HIV transmission |
| For each cluster of concern identified through analysis of surveillance and other data, submit analysis and response results to CDC quarterly after identification of cluster until investigation and intervention activities are closed. | Documentation of submission of analysis and response results to CDC | APR, SER, cluster report forms  Frequency: Annual |

## Section 5: Data Management Plan (DMP) – Component A

Please ensure that personally identifiable information (PII) is appropriately collected, processed, stored, and protected to maintain compliance with public laws, federal regulations, and executive orders.

**Note**: The management, security, and confidentiality of data for the PS20-2010 project should be addressed and updated in the PS20-2010 DMP. The DMP must be updated annually or when any significant change is made to a data set or system to ensure that the DMP remains current throughout the lifecycle of the project.

Table 8

| **Data Management Plan Elements** | | |
| --- | --- | --- |
| **Elements** | **Surveillance Data** | **NHM&E Data** |
| Description of data collected and standards used. Include information on data sources or other databases if used (e.g., conforms to standards outlined in CDC technical guidance for HIV surveillance, etc.). |  |  |
| Data steward(s) |  |  |
| Mechanisms for within-agency limiting or sharing of data and justifications (e.g., data sharing agreements and process for using them) |  |  |
| Mechanisms for sharing data with partners (e.g., CPG, Ryan White) |  |  |
| Description of data release policies and procedures including precautions to protect confidentiality (e.g., data suppression criteria, other restrictions). |  |  |
| Mechanisms for making data available to the public (e.g., reports, epi profile, datasets, CDC Atlas plus). Include description of prerelease data quality reviews and validation, data suppression checks. Address access to identifiable and de-identified data. |  |  |
| Statement that procedures are in place to ensure all released data have appropriate documentation and any limitations described. |  |  |
| Description of steps taken to protect privacy and ensure confidentiality and security of data. Refer to applicable policies and statement signed by the overall responsible party (ORP) certifying program compliance with the NCHHSTP Guidelines |  |  |
| Description of data archiving policies or provide explanation for why long-term preservation and access are not required. |  |  |

**Add any additional notes here:**

Click to enter text.

## Section 6: Human Subjects

Please place an “X” in the appropriate box to indicate whether or not a Human Subjects Protection/Institutional Review Board approval is needed for any aspects of your non-research project.

|  |  |
| --- | --- |
| Yes |  |
| No |  |

# **Targets and Local Objectives** – **Component A**

## Section 7: Targets and Local Objectives – Component A

Please insert your yearly targets and local objectives for your proposed activity and indicator(s) below.

Table 9

| **Targets and Jurisdiction Objectives** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Indicator** | **Local Program Objectives** | | | | | |
| **Baseline** | **Yr 1** | **Yr 2** | **Yr 3** | **Yr 4** | **Yr 5** |
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# **Appendix A: Logic Model**

Below is the CDC [logic model](#logicmodelComponentAAppendixA) for PS20-2010, including strategies, short-term outcomes (e.g., increased referral and linkage of persons with indications for PrEP), and intermediate outcomes (e.g., increased knowledge of HIV status).

You may adopt this logic model for your local PS20-2010 program without modification. However, if you wish to include more detail in your logic model, please use the space in Section 1 to describe any additional outcomes.

Note: PS20-2010 EPMP Version 1.0 applies to Component A of the logic model and should not be completed for Component B or Component C.

Table 10

| **PS20-2010 Logic Model – Ending the HIV Epidemic** | | | | |
| --- | --- | --- | --- | --- |
| **Strategies** | | **Short-Term Outcomes** | **Intermediate Outcomes** | **Long-Term Outcomes** |
| **Component A: Ending the HIV Epidemic Initiative (EHE) - Core** | | | | |
| **Diagnose** | * Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities * Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings * Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings | * Increased routine opt-out HIV screenings in healthcare and other institutional settings * Increased local availability of and accessibility to HIV testing services * Increased HIV screening and re-screening among persons at elevated risk for HIV infection | * Increased knowledge of HIV status * Reduced new HIV diagnoses | Reduced new HIV infections |
| **Treat** | * Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV * Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs | * Increased rapid linkage to HIV medical care * Increased early initiation of ART * Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care * Increased support to providers for linking, retaining, and re-engaging PWH to care and treatment | * Increase viral suppression among persons living with diagnosed HIV |
| **Prevent** | * Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indication for PrEP * Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs) | * Increased screening for PrEP indications and linkage to PrEP providers among HIV-negative clients * Increased referral and linkage of persons with indications for PrEP * Increased access to SSPs | * + Increased PrEP prescriptions compared to number with indications (PrEP coverage) overall and in areas with high HIV diagnosis rates.   + Decreased racial and ethnic disparities in PrEP provision   + Increased knowledge about the services and evidence-base of SSPs in communities   + Increased quality of evidence-based SSP service delivery |
| **Respond** | * Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response * Investigate and intervene in networks with active transmission * Identify and address gaps in programs and services revealed by cluster detection and response | * Increased health department and community engagement for cluster detection and response * Improved surveillance data for real-time cluster detection and response * Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks | * Improved knowledge of networks to contain HIV transmission clusters and outbreaks   + Improved response to HIV transmission clusters and outbreaks   + Improved data systems for real-time cluster detection and response |
| **Component B: HIV Incidence Surveillance\*** | | | | |
|  | * Work with stakeholders (e.g., community, laboratories, and providers) to identify best practices for implementing a recency-based incidence surveillance * Conduct recency-based HIV incidence surveillance in selected jurisdictions * Review incidence results from a CD4 depletion model and a recency-based assay model | * Improved coordination with stakeholders including community, laboratory, and clinical providers to develop recency-based incidence surveillance * Increased capacity to collect recency-based assays from all persons aged 13 years and older with a new HIV diagnosis | * **Estimate HIV incidence in selected jurisdictions using a recency-based assay** * Review HIV incidence using a CD4 depletion model and a recency-based assay model |  |
| **Component C: Scaling up HIV prevention services in STD clinics\*** | | | | |
|  | * Conduct assessment of clinic infrastructure to document current HIV/STD prevention services, identify gaps, and assess service quality * Implement evidence-based approaches to scale up capacity for sexual risk assessments, self-collected STD testing, timely treatment, and HIV-related tests * Expand capacity of STD clinics to offer PrEP/nPEP and strengthen clinic and laboratory capacity for recommended follow-up visits * Optimize linkage to, retention in, and re-engagement in HIV medical care * Facilitate partnerships with community HIV clinical providers, health departments and community-based organizations for implementation of the EHE | * **Increased identification of new HIV and STD infections in STD specialty clinics** * **Increased rapid linkage to care for individuals newly diagnosed with HIV at STD specialty clinic** * **Increased identification of virally unsuppressed people in STD specialty clinics** * **Increased re-engagement to care for persons living with HIV who are not virally suppressed** * **Increased screening for PrEP/nPEP indication in STD specialty clinics** * **Increased PrEP-eligible individuals in STD specialty clinics who are offered and initiate PrEP, if indicated** | * + Increased knowledge of HIV status   + Increase viral suppression among persons living with diagnosed HIV   + Increase persons receiving PrEP/nPEP | Reduced new HIV infections |

\*Note: Component B and C are not addressed in this EPMP.